From:	Bill Pully
To:	*TE/GE-EO-F990-Revision;
CC:	Advocacy;
Subject:	Comments on Draft Form 990
Date:	Thursday, September 13, 2007 11:23:29 AM
Attachments:	IRS_NCHA_letter_2A.pdf ATT2357572.htm

Comments on Draft Form 990 attached.

NCHA
PO Box 4449
Cary, NC 27519 - 4449

919 / 677-2400
919 / 677-4200 fax
www.ncha.org

September 13, 2007

Internal Revenue Service
Form 990 Redesign, SE:T:EO
1111 Constitution Avenue, NW
Washington, D.C. 20224

RE: Comments on Draft Form 990

On behalf of the North Carolina Hospital Association, thank you for the opportunity to comment on the draft Form 990, particularly Schedule H and accompanying schedules. We appreciate the Service's openness to comments and the work done already to create a workable platform for reporting hospitals' community benefits.

Our initial reactions to the Form and Schedule H include concerns that the transition period is far too short, the administrative burden of collecting certain information outweighs its usefulness to the public, the full value of our hospital's community benefit cannot be calculated using Schedule H and the Service is requesting information unrelated to community benefit that will have no value to the public or will lead to misinterpretation by the public.

NCHA and its member hospitals have numerous concerns about the core form and its schedudules, particularly Schedule H. A number of these concerns are outlined in the American Hospital Association's September 6, 2007, letter to the Service. Nonprofit hospitals are among the entities most affected by the changes in the Form 990, with some hospitals facing the need to file a dozen or more of the Form's schedules. We recomend that the Service review the concerns raised by hospitals, publish a revised draft of the form and schedules, and provide additional time for hospitals and others to review and comment on the revisions and prepare for implementation. Schedule H alone requires significant revision to address the questions raised by the current draft.

Our specific concerns about the core 990 form and its schedules are included later in this letter. With regards to Schedule H, we are most concerned that:

- Medicare losses should be explicitly documented,
- Proposed bad debt treatment causes overstatement of some community benefit items, and
- A single costing methodology is preferred.

In addition to these we have concerns related to specific areas in the Instructions and Worksheets of Schedule H. These issues are discussed in depth below.

We have organized all our comments in this letter by the reference area (e.g. worksheet 1), starting with our general 990 comments, then our three most important suggestions to improve Schedule H, followed by specific suggestions, ordered by its approximate location in Schedule H, and then a suggested list of missing Community Benefit items from Schedule H. The last two pages of this letter give a cross reference of each issue, letter page number, and Form 990 location.

Comments on the Core Form and Schedules Other Than Schedule H

Issue: **Some of the required disclosures may be misleading to the public.**

For example, Form 990, Part I's requirement that total executive compensation be shown as a percentage of total program expenses does not accurately reflect a hospital's financial operations. In addition, the calculation of fundraising expenses as a percentage of grant revenues and total expenses as a percentage of net assets are not helpful to the public in understanding a hospital's financial operations.

Recommended revision: See the American Hospital Association's recommendations in their September 6, 2007 letter. We recommend a delay in the adoption of a new Form 990 to provide additional time for the Service to clarify and revise the form and its accompanying schedules and to provide hospitals adequate time to prepare for implementation.

Issue: **Some of the disclosures require substantial data collection by the hospital.**

Some of the disclosures require substantial data collection by the hospital, diverting resources that are needed for critical functions. Many of our hospitals anticipate that additional staff will be needed to collect the information needed to complete the new form and schedules. For example, Form 990, Part II requires that the hospital collect information on and report executives' and trustees' business relationships during a five-year look-back period. This is particularly burdensome for a hospital with a large board or a hospital that enters into hundreds of business relationships. In addition, Form 990, Part III requires hospitals to indicate whether their governing boards have reviewed the completed Form 990. If the Service intends that each Board member review the Form 990 and its multiple schedules, with no ability to rely on review by the Finance Committee or a similar committee of the board, this will divert valuable trustee time from their other governance responsibilities and could potentially dissuade some volunteers from serving on hospital boards in the future.

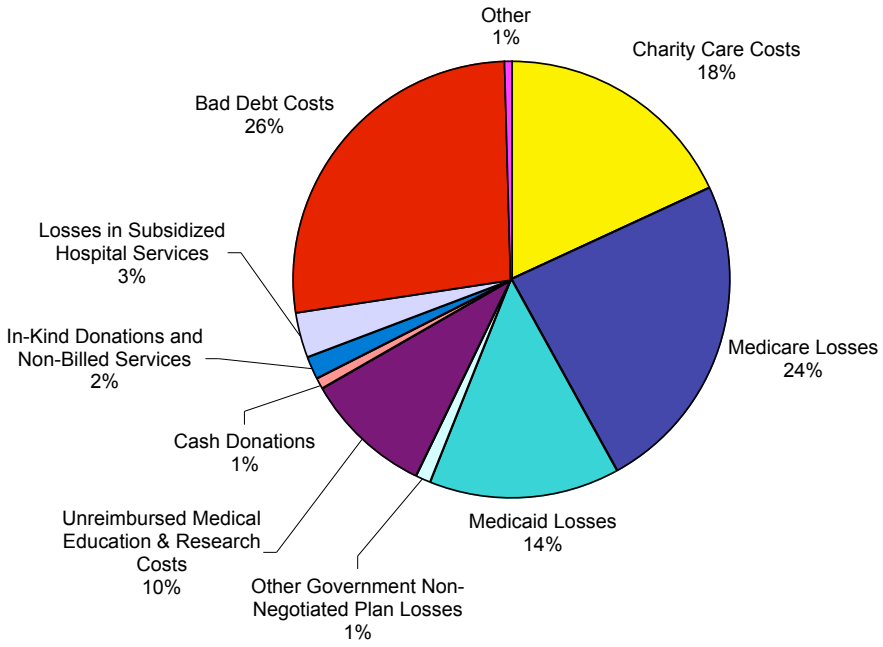
Recommended revision: See the American Hospital Association's recommendations in their September 6, 2007. As noted above, we recommend a delay in the adoption of a new Form 990.

Schedule H – General Comments

Issue: **Medicare losses should be explicitly documented.**

It is unclear from the form whether Medicare losses are to be lumped into "Other government programs" or omitted. It should be listed as its own category. Medicare is a public program of non-negotiated reimbursement rates covering a large population in the US. Through its revenue ruling on

community benefit, the IRS has recognized that providing hospital care for persons covered by public programs such as Medicare is a community benefit (Rev. Ruling 69-545; Legal Issues related to Tax Exemption and Community Benefit, National Health Lawyers Association, 1996). Our state collects information on Medicare losses and has distinctly recognized those losses as a community benefit since 2001. Losses on Medicare are an important part of a hospital's community benefits. Medicare accounts for 43% of all utilization in North Carolina hospitals. In FY06 for North Carolina these losses represented the second highest category of community benefits, accounting for 24% of all



Community Benefits.

In North Carolina, the vast majority (79%) of hospitals do not receive enough Medicare reimbursement to cover costs of care. While North Carolina hospitals' Medicare reimbursement averages 92% of costs, the same as the national average, its high volume makes for high dollar losses (over half a billion dollars for FY06). Without these losses, a community benefits report is dramatically understated and the national problem of Medicare losses masked.

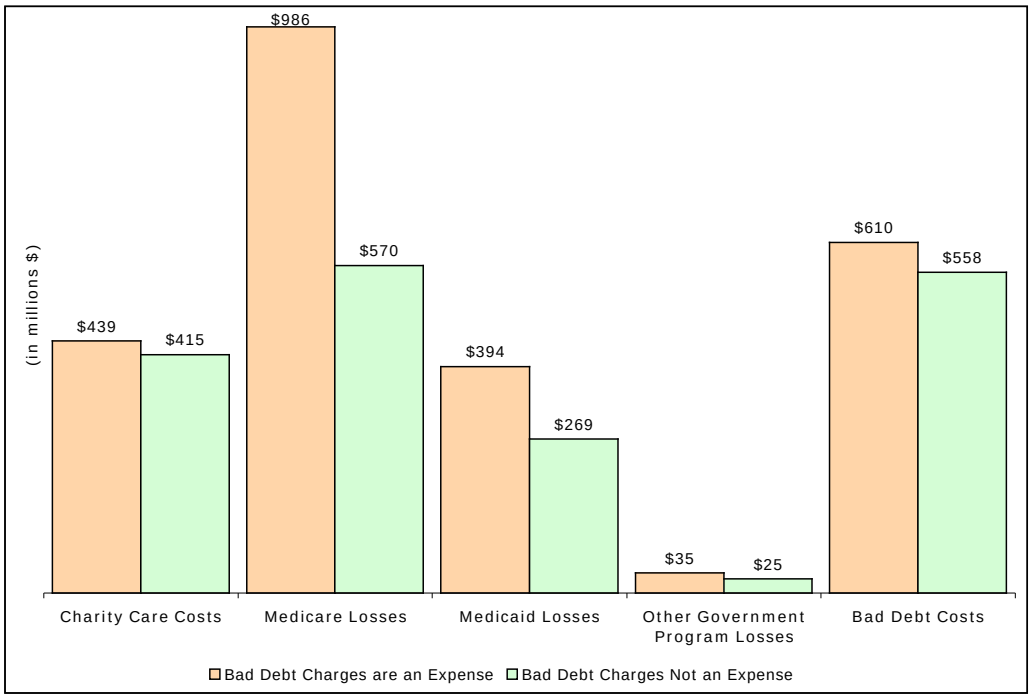
Recommended revision: Medicare losses should be explicitly listed in Part I of Schedule H. Listing those losses will make Schedule H consistent with the law that defines a tax-exempt hospital.

Issue: **Proposed bad debt treatment causes overstatement of some community benefit items.**

A substantial portion of bad debt is pending charity care. Unlike bad debt in other industries, hospital bad debt is complicated by the fact that hospitals

follow their mission to the community and treat every patient that comes through their emergency department, regardless of ability to pay. Patients who have outstanding bills are not turned away, unlike other industries. Bad debt is further complicated by the auditing industry's standards on reporting charity care. Many patients cannot or do not provide the necessary, extensive documentation required to be deemed charity care by auditors. As a result, roughly 40% of bad debt is pending charity care. The majority of bad debt is from uninsured patients; in North Carolina two-thirds is from uninsured or patients with Medicare, Medicaid, or other public programs. Hospitals deserve the opportunity to tell the whole story of the impact of the uninsured on a hospital community benefit report. Currently this story is hidden in Schedule H.

As Schedule H is currently written, the size of a facility's total bad debt charges impacts numbers reported in Part I. The story is hidden in every cost line item that is based on Worksheet 2's ratio of cost to charges (RCC) calculation. It is an accepted industry practice to use the ratio of a hospital's total costs to its total charges to estimate costs for a sub-population of the facility's patients. In Worksheet 1, for example, the RCC used charity care charges to estimate the hospital's costs of treating Charity care patients. Where costing methodologies differ is in what counts in the RCC's total costs. Worksheet 2 instructs hospitals to include all hospital costs, including bad debt charges. This leads to bad debt charges being included in estimates of costs. In North Carolina, Medicaid accounts for 15% of charges, so hospitals using Worksheet 2 would produce an estimate of Medicaid costs that includes 15% of total bad debt ***charges***. Clearly, this is misleading. The Financial Accounting Standards Board (FASB) accounting standards count bad debt charges as an operating expense. Neither the Governmental Accounting Standards Board (GASB) accounting standards nor the Form 990, Part V, count them. Approximately one-half the North Carolina hospitals follow GASB. Since GASB is the official government accounting standards, the IRS should consider adopting that standard. It is important to note that GASB standards will lower estimates of every loss in Part I that uses Worksheet 2. The North Carolina Hospital Association has done extensive research on the impact of bad debt on RCCs and subsequently on community benefit items. The chart from that report has been updated below with FY06 totals for North Carolina.



Including all bad debt charges in the ratio of cost to charges results in a doubling of Medicare loss estimates and Medicaid loss estimates inflated by 50%. This artificial increase in loss estimates is driven entirely by the inclusion of charges for bad debt in the costing methodology.

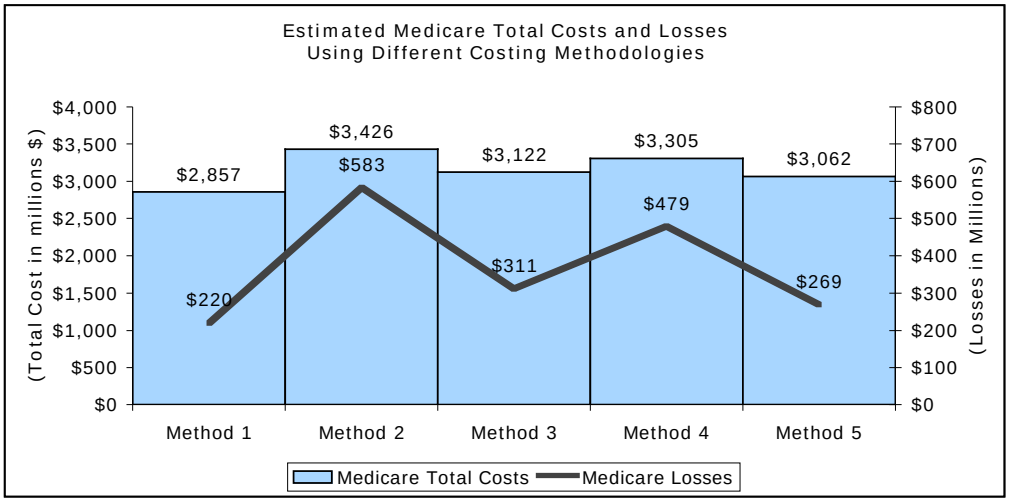
Total expenses should not be composed of charges, which are the prices hospitals set, but should be based only on the expenses related to the care of patients. At the same time, the story of the whole community, including the uninsured and pending charity care cases, must be included in each hospital's community benefits report.

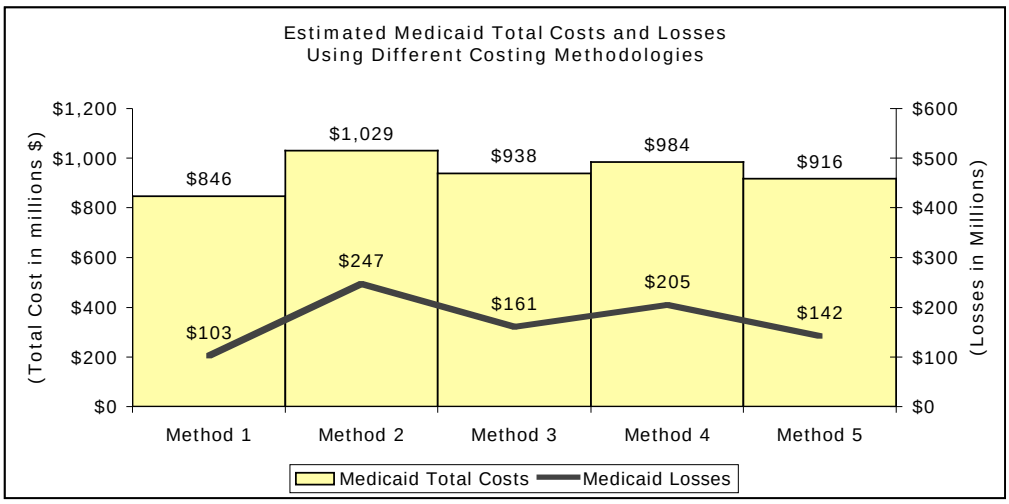
Recommended revision: List costs of care from bad debt on the community benefit report and remove bad debt charges from Worksheet 2's ratio of cost to charges calculation. In this way, the community benefit related to bad debt is not passed through to other community benefit items and the benefit for these mostly uninsured, community members is extracted and listed on the report. Because of the unique nature of bad debt, we recommend it be included in the "Other Benefits" section of Part I and that, like charity care, it be reported at cost, using the same methodology. The new category should be labeled to indicate that it includes pending charity care patients that cannot be separated from bad debt: "Bad Debt and Pending Charity Care Costs."

Issue: **A single costing methodology is preferred.**

The North Carolina Hospital Association has done extensive research on the impact of costing methodologies on community benefit items. Small changes in

costing methodologies can dramatically affect estimates of government program losses.





Differences in costing methodologies can produce a 20% difference in total costs estimates and can produce loss estimates that vary by as much as 165%. In effect, choosing a different method to calculate costs can more than double estimates of losses.

At best, allowing multiple costing methodologies would produce reports that cannot be compared fairly across hospitals. At worst, it will punish hospitals without the resources to review the differences in the methodologies.

Recommended revision:

Given the current pressure on reporting community benefits, it is vitally important that this report produce comparable statistics. To do this, one costing methodology should be chosen so that the playing field is level. The current worksheets give hospitals the option between a cost accounting system and Worksheet 2's Ratio of Cost to Charges. Most hospitals do not have the financial resources to have a cost accounting system and the personnel to produce an extensive costing report. The ratio of costs-to-charges in Worksheet 2 is Method 4 above. We recommend that estimates should be based on the

formula for the ratio of cost-to-charges (RCC) for Method 5 above:

Total expenses (not including bad debt) / (Total charges + Other operating revenue)

Method 5 has the following advantages:

- Allows for consistency and comparable statistics nationwide.
- Has been used by the American Hospital Association for years and is their preferred formula for Community Benefits. This RCC has a long track record in the United States and is used in many publications about hospital costs.
- Does not hide bad debt charges and other non-patient care expenses in the report. (See previous comment).
- Unlike CMS' Medicare Cost Report's RCC, it includes all services provided in the hospital and does not exclude necessary expenses, such as professional liability insurance. The Medicare Cost Report's RCC is higher than other RCCs for some hospitals and lower for others. This lack of consistency is driven by their list of excluded services, charges, and costs and therefore, it doesn't represent the activities of the whole hospital.
- Does not tie Community Benefit amounts to the politically motivated CMS Medicare Cost Reports for allowable services and expenses. By removing this tie, numbers can be trended and will not reflect the definitional changes that occur when CMS changes its cost report definitions.
- Eliminates non-patient care expenses with an estimate of other operating expenses (other operating revenues). On a technical note, Worksheet 2 currently does this by subtracting this from the numerator. Adding other operating revenues to the denominator of the ratio produces very similar results to subtracting from the numerator. It is not our point that one of these two approaches is significantly better than the other.
- Can be calculated from readily available, audited, financial data in every hospital. Having an RCC that is easily calculated reduces unnecessary burdens on hospitals when completing filing requirements.

Instructions for Schedule H

Issue: **Aggregation of community benefits across non-like facilities creates meaningless comparisons**

Large healthcare organizations may be combined under one Employer Identification Number. These organizations typically contain a variety of healthcare facilities (hospitals, nursing home, primary care physician offices, etc). Each of these markets has entirely different community benefit responses. For example, Medicaid often represents over 80% of nursing homes residents, leaving little room to perform any other community benefit. Combining these facilities into one community benefits report produces amounts that cannot

fairly be compared to other healthcare organizations. Adjusting for organization size, as is done be column f in Part I, will do nothing to correct for different compositions.

To demonstrate the diversity of these groups note that a large healthcare system will show different community benefit amounts for items that use Worksheet 2's ratio of cost to charges (RCC) when the system aggregates all its financials into one RCC and calculate a combined Community Benefit report, or if it calculates Worksheet 2's RCC for each facility, creates a community benefits report for each facility and then adds each facility's community benefit report together for the combined report.

Recommended revision: Ask that systems either provide just an aggregated hospital community benefit reports or two community benefit reports: One for just the hospitals within the system and a second for the entire system. The IRS should choose which aggregation method to use for the RCC or systems will choose differing methods which will give amounts that cannot be compared.

Schedule H – Part I (Community Benefit Report)

Issue: **Medicare should be explicitly listed in Part I.**

For the reasons outlined earlier in this letter:

- Medicare is a public program of non-negotiated reimbursement rates covering a large population in the US.
- Through its revenue ruling on community benefit, the IRS has recognized that providing hospital care for persons covered by public programs such as Medicare is a community benefit (Rev. Ruling 69-545; Legal Issues related to Tax Exemption and Community Benefit, National Health Lawyers Association, 1996).
- Our state collects information on Medicare losses and has distinctly recognized those losses as a community benefit since 2001.
- In North Carolina, the nearly 80% majority of hospitals do not receive enough Medicare reimbursement to cover costs of care.

Medicare losses should be recognized in a separate category in Part I.

Recommended revision: Add Unreimbursed Medicare before Unreimbursed "Other Government Programs" in Part I

Issue: **Bad Debt should be explicitly listed in Part I.**

For the reasons outlined earlier in this letter:

- Patients who have outstanding bills are not turned away, unlike other industries.
- Many patients cannot or do not provide the necessary, extensive documentation required to be deemed charity care by the auditing industry.

- As a result, roughly 40% of bad debt is pending charity care.
- The majority of bad debt is from uninsured patients.
- Hospitals deserve the opportunity to tell the whole story of the impact of the uninsured on a hospital community benefit report.

Bad debt charges should not be invisibly spread across all unreimbursed losses, but explicitly listed as a community benefit.

Recommended revision: Bad debt should be measured in costs, accurately labeled as "Bad Debt and Pending Charity Care Costs" and included in Part I. We recommend putting it in the "Other Benefits" section of Part I.

Issue: **Instructions for Line 9: Cash and In-Kind contributions should not be restricted to health entities only.**

Often hospitals donate items that may not be directly tied to health but are needed to the community. For instance, a hospital may donate a fire truck to the local fire station, or staff time or lab time to the local school for education or mentoring or staff time to the Katrina victims effort. Most places acknowledge all donations made by hospitals to government agencies or non-profits as hospital provision of community benefits. Provision of a community benefit is something that is a benefit to the community, not strictly an immediate health benefit to the community.

Recommended revision: Remove health restriction from definition.

Issue: **Prior period adjustments need to be explicitly handled for Medicaid (and all government plan) losses.**

The instructions must detail how hospitals should handle prior period adjustments. Often hospitals hold some revenues in reserve until cost reports are settled. Typically once settlement occurs, any remaining reserves are released into current revenues. If the reserves are inadequate then additional current year revenues are used to re-pay any balance. CMS's retroactive adjustments necessitate this practice. The delay in settlement can be lengthy: In North Carolina the 1997 cost reports were not settled by CMS until 2006.

Most auditors reflect the entire adjustment in current year government program revenues, which can cause large fluctuations in yearly government program loss estimates (since they are incorporating into current year revenues the revenue adjustments for activities years old). Some hospitals may choose to calculate losses associated with strictly current year patients in Worksheet 3 by not incorporating prior period adjustments into current year payor net revenues, and restricting the estimate to just current year government program revenues. However, this has the unintended consequence that prior period adjustments and corresponding released reserve revenues are never captured in government program losses.

Recommended revision: While the instructions should clearly state that revenues should tie to their audited financial statements (and therefore prior period reserves released into current year revenues should be counted in current year government program revenues, if their auditors so indicated), hospitals should be given an opportunity to also state what their government program losses would be without this adjustment.

A line should be added as a note under Schedule H, Part I, Unreimbursed Medicaid that allows this amount to be reported (and similarly for Medicare and other government programs).

Issue: **"Number of activities or programs" (a) and "Persons served" (b) columns in Part I are misleading and burdensome to calculate.**

The instructions say to calculate (a) for "Other Benefits" only, but the boxes for government and charity care are not grayed in. If these columns remain here, they should be grayed in so that it is clear at a glance that these are not applicable.

Number of activities or programs (a) and Persons served (b) are columns that do not make sense for any of the categories listed as a community benefit. For example, a hospital may donate several of its staff nurses to schools. Trying to apply these two questions to just this one type of donation is not clear: What are the numbers of activities or programs?

- Nurses sent to schools?
- Schools served?
- One?

What are the numbers of persons served?

- Children enrolled in each school?
- School days covered by the nurses?
- Children multiplied by the school days covered?
- Population in the community?
- Children given shots or seen by nurses?
- Total number of visits to nurses' offices?

Each possible program would require strict counting instructions to get consistent responses. Even if these categories were defined rigorously in the instructions, the burden on hospitals to calculate this would be incredible: Most IT systems don't report their visit data in this fashion. Most public relations departments do not track expenses on public service materials. Once hospitals did implement systems to track this information, the report would not be helpful: the sum of these for a total number of programs or persons served is not comparable and a meaningless measure of community benefits.

There are related questions for every category of community benefits listed.

For example, Research: Is number of activities the number of participants enrolled in research programs? Number of researchers? Number of visits? Number of facilities? Everyone benefits from successful research; perhaps "persons served" should be everyone in the hospital?

Community Health Improvement Services: If a hospital produces a Public Service Announcement on stroke care, is the number of activities one, or the number of times it was shown? Should the hospital count the entire local population, multiplied by the number of times shown, as "persons served?"

Totaling these only compounds their unreliability and irrelevance. This is not an accurate measure of community benefits.

Recommended revision: These columns are confusing and misleading to the public. Hospitals would require new program utilization tracking systems to be built and implemented; an expensive and burdensome task. There is no mechanism to construct these columns that will lead to comparable reports other than to measure their size in terms of costs. Columns (a) and (b) should be removed from Part I.

Issue: **"Charity Care" title and "Total Charity Care" are incorrect labels in Part I.**

Charity care has a prescribed accounting definition and it is not the sum of charity care, unreimbursed Medicaid, and unreimbursed costs from other government programs. Charity care is just charity care. This label will confuse providers and consumers.

Recommended revision: Either remove this sub-total line or re-label it accurately. For example:

- Total public program and charity care, or
- Total government and charity care.

Schedule H – Part II (Billing and Collection)

Issue: **Section A: Billing and collection practices are irrelevant to measuring community benefits.**

First, terms such as "net expected" and "fees collected" would need careful definitions, because they are ambiguous. Some hospitals might expect their patient populations to pay all their bills and others might expect the percent paid to be what it has been in the past. "Fees" are not a usual term for payments received by the hospital.

Where should bad debt go? Under the Financial Accounting Standards Board (FASB) accounting standards bad debt charges count as an operating expense. This would imply that bad debt charges should be included in "net expected" and "fees collected." The Governmental Accounting Standards Board (GASB) accounting standards say that bad debt is a deduction from charges. Hospitals

following these standards would expect a line for bad debt in the table. Approximately half of the hospitals in North Carolina follow FASB, and half GASB.

This section looks like an attempt to insert an abbreviated hospital income statement into this schedule. Not-for-profit hospitals already make their financial statements public; that information should not be replicated on a schedule intended to measure community benefits. The purpose of Schedule H is to "quantify, in an objective manner, the community benefit standard applicable to tax-exempt hospitals." Community benefit is what the hospital provides to the community. Hospitals use a varied of criteria upon which to base their policies for determining which patients qualify for charity care and what portion of their bill qualifies as charity. Unless the goal is to enable uninsured persons use IRS Form 990 to shop for healthcare services based upon which hospital has the most liberal policies, this section is irrelevant.

Recommended revision: Remove Section A

Issue: **Definition of patient's payor source in the instructions conflicts with national standards**

The second paragraph of the instructions which starts with "If a patient has more than one type of insurance the care provided to the patient is to be classified under the first program listed…" conflicts with national standards. It is not in accordance with the National Coordination of Benefits. For example a patient age 65 still working with private commercial insurance has the private commercial insurance as primary before Medicare. On the chart in the instructions Medicare is first.

Recommended revision: We recommend the removal of Part II entirely. Barring that, we recommend either re-orderings payors in the order specified by the National Coordination of Benefits or explicitly stating the order in accordance with the National Coordination of Benefits.

Issue: **How should charity care charges be treated?**

Section A, Line 1 (Gross Charges) has no separate category for charity care. Should they be removed from this chart or added in by the patient's primary payor (mostly uninsured)? Perhaps a line should be added in the chart that indicates how much charity care is in each payor? How will information in this chart be tied to Part I (which explicitly lists charity care, Medicaid and other government programs)?

Recommended revision: We recommend the removal of Part II entirely. Barring that, explicitly define in the instructions how these two parts go together to represent charity care and other payor information.

Schedule H – Part III (Management Companies and Joint Ventures)

Issue: **"Management Companies and Joint Ventures" is irrelevant to a community benefits report.**

This section does not contain information relevant to measuring community benefits. Under the IRS ruling there are five factors to consider when determining whether a hospital qualifies for tax-exemption. Information about the percent ownership of a hospital in other entities to provide services to the community is not in any of these five.

Recommended revision: Remove Section B

Schedule H – Part IV (General Information)

Issue: **Question 1 (Assessment of Community Needs) will not generate distinct answers.**

This question is vague and will generate the same vague answer from each hospital: "We perform a gap analysis." While this question is innocuous, it will not provide any helpful information into the provision of community benefits for the public.

Recommended revision: Remove this question.

Issue: **Question 2 (Education of patients about public programs and charity care policy) does not provide a measure of community benefits.**

This question will not generate a useful response for the public. As noted in the IRS's "Hospital Compliance Report, Interim Report (Summary of Reported Data)" hospitals uniformly facilitated the enrollment of all uninsured patients in any public program for which they were eligible. Hospitals also have an incentive from their community benefit report to capture every patient eligible for charity care as soon as possible. At what point in a patient's stay this education activity takes place depends upon the state of the patient and when the appropriate opportunity is available. Unconscious patients arriving at the ED cannot be educated right away.

Recommended revision: Remove this question.

Issue: **Question 3, Which ED policy and procedures should be described?**

Each ED has policies and procedures to cover everything from how to treat each diagnosis to how to handle each type of disaster. As written, this question

will not inform measures of community benefits.

Recommended revision: Please be specific about the nature of the policies and procedures you wish to understand. Their connection to Community Benefits should be clear:

- Please describe your ED policy and procedures for informing patients of their access to charity care policies.
- Please describe your ED policy and procedures for informing patients of their responsibilities to pay.

Schedule H – Worksheet 1 (Traditional Charity Care)

Issue: **Single costing methodology leads to more comparable results**

For the reasons outlined earlier in this letter:

- Differences in costing methodologies can produce a 20% difference in total costs estimates.
- At best, allowing multiple costing methodologies produces reports that cannot be compared fairly across hospitals. At worst, it will punish hospitals without the resources to review the differences in the methodologies.

Hospitals should not be given a choice on methods to calculate costs. Because most hospitals do not have a cost-based accounting system and there is no published research that all cost-based accounting systems calculate costs at the same level of accuracy, a single costing methodology should be the only allowed costing methodology. In this way, estimates are based on the same methodology and are comparable.

Recommended revision: Eliminate "Method 2: Cost accounting system" column.

Issue: **Lines 2-3: Inpatient and Outpatient breaks-outs are very difficult to provide.**

Within current financial systems, many hospitals are unable to break out charges both by source and inpatient/outpatient status. In March of 2003 NCHA asked a sample of NC hospitals in a survey how difficult it would be to break out inpatient and outpatient charges by source (e.g. Medicare, Medicaid, Charity Care) and half responded that it was either not possible or very difficult for them to do so. A community benefits report does not need this break out to calculate costs. It is extra information that would be burdensome for hospitals to provide and gives no benefit for the community benefit report.

Recommended revision: Remove lines 2-4 on Worksheet 1.

Issue: **Line 8: Direct contributions to charity care programs may be double-counted.**

The instructions should be clear that these contributions should not be reported on Schedule H, Part I, Question 9 (Cash and in-kind contributions). Without this clarification, hospitals may unintentionally double-report these amounts. Also, because hospitals both give and receive contributions, it should be made clear that these are contributions made by the entity (and not those given to the hospital).

Recommended revision: Clarify in the directions that these are contributions made by the entity to charity care programs and that they should be separate from the amounts included in the Cash and In-Kind Contributions line in Schedule H, Part I, Question 9.

Issue: **Line 11 mixes charity care and uncompensated care and lines 10-14 should be combined into one line and the types of reimbursements moved into the instructions.**

In line 11 ("Payments from uncompensated care pools or programs"), the term "uncompensated" means something very specific to hospitals: bad debt plus charity care. Since this section is calculating charity care costs only, then only charity care payments should be included.

Lines 11-13 are various forms of funding sources for charity care. Why separate them? Instead lump them into one amount. In this way hospitals will spend less time trying to distinguish "philanthropy" from "pools or programs." These specific types of reimbursement can be listed in the directions for line 14.

Recommended revision: Remove lines 11-13 leaving just "offsetting revenues." Add a description in the instructions for these types of revenues, making it clear that the revenues are for charity care programs (do not use the term uncompensated care).

Schedule H – Worksheet 2 (Ratio of Costs to Charges)

Issue: **Bad debt should not be hidden in cost to charge ratio.**

For the reasons outlined earlier in this letter:

- Including all bad debt charges in the ratio of cost to charges results in artificially inflating all cost estimates, including doubling Medicare loss estimates and Medicaid loss estimates inflated by 50%.
- Total expenses should not be composed of charges, which are the prices hospitals set, but should be based only on the expenses related to the care of patients.
- Cost of bad debt care should be explicitly listed; not evaluated at

charges and unevenly spread across all cost estimates.
Line 2 should not include bad debt charges.

Recommended revision: Change the words in line 2 to:
2. Total operating expenses (excluding bad debt charges)
Remove the phrase "(including bad debt charges)" from line l2. Total gross charges. Without it, the entity will give total charges, but with the phrase they may believe they are being asked to double-count them.

Issue: **Community benefit amounts likely double counted**

The formula for the ratio of cost to charges (RCC) asks hospitals to remove costs of Subsidized Health Services from expenses (because Subsidized Health Services are already listed on the report), but does not make it clear that it should exclude any other community benefits listed:

- Part I.5 Community Health Improvement Services and Benefit Operations Costs
- Part I.6 Health Professional education costs
- Part I.8 Research costs
- Part I.9 Costs of providing Cash and In-kind contributions.

Without these exclusions, all the dollars for these expenses would appear in their corresponding Part I sections, and also in charity care costs, unreimbursed Medicaid and Unreimbursed costs of other government programs. *(Note: Line 8 might be intended to remove these, but it is unclear what goes in that line.)*

Recommended revision: Add comments for Worksheet 2, line 8:
All costs corresponding to Part I.5, I.6, I.8, and I.9 should be included here.

Issue: **What is line 7 "Expenses for other programs for person qualify for charity care"?**

This is probably a reference to Line 8 in Worksheet I (Traditional Charity Care). If so, the instructions should indicate that. Otherwise, hospitals are likely to include any costs related to providing charity care (the salary, benefits, supplies, and other expenses associated with determining and managing charity care cases). This would make the ratio unable to correctly estimate any costs.

Recommended revision: Remove lines 7 and 8 and replace with "Entity expenses used to calculate Other Benefit line items". Make sure in the definition it says those expenses that are also in total expenses (line 2).

Issue: **Directions for Lines 6 & 14 (Operating Expenses and Gross Charges for Subsidized Health Services) are not correct.**

The note at the bottom says these should only be removed if the hospital has a

cost based accounting system. Some hospitals may interpret this to say that if they have a cost accounting system they should not fill out lines 6 and 14. It is likely the directions are attempting to address the double counting mentioned above, particularly when Worksheet 2's RCC is used to calculate Subsidized Health Services' costs.

Recommended revision: Change note to discuss the precise way to adjust this worksheet based on how subsidized hospital service losses will be calculated:
If Worksheet 2 will be used to calculated Worksheet 6, Line 6B (costs of Subsidized Health Services), then expenses and charges for these services should be included in Worksheet 2's charges and costs (lines 10 and 16) and not removed (leave lines 6 and 14 blank). If, however, another methodology is to be used to calculate Subsidized Health Services' costs, then the costs and charges for these services should be removed from Worksheet 2's "10. Adjusted total operating expenses" and "16. Adjusted total gross charges" via completion of lines 6 and 14 above.

Schedule H – Worksheet 3 (Unpaid Costs of Medicaid and Other Public Programs)

Issue: **Single costing methodology leads to more comparable results.**

For the reasons outlined earlier in this letter:

- Differences in costing methodologies can produce a 50% difference in total costs estimates.
- At best, allowing multiple costing methodologies produces reports that cannot be compared fairly across hospitals. At worst, it will punish hospitals without the resources to review the differences in the methodologies.

Hospitals should not be given a choice on methods to calculate costs. Because most hospitals do not have a cost-based accounting system and there is no published research that all cost-based accounting systems calculate costs at the same level of accuracy, a single costing methodology should be the only allowed costing methodology. In this way, estimates are based on the same methodology and are comparable.

Recommended revision: Eliminate "Method A: Cost accounting system" row.

Issue: **Lines 8-9: Inpatient and Outpatient breaks-outs are very difficult to provide.**

Within current financial systems, many hospitals are unable to break out charges both by source and inpatient/outpatient status. In March of 2003 NCHA asked a sample of NC hospitals in a survey how difficult it would be to break out inpatient and outpatient charges by source (e.g. Medicare, Medicaid, Charity Care) and half responded that it was either not possible or very difficult for them to do so. A community benefits report does not need this break out to

calculate costs. It is extra information that would be burdensome for hospitals to provide and gives no benefit for the community benefit report.

Recommended revision: Combine lines 8-9 on Worksheet 3 into "Medicaid Net Revenues". The instructions will have to make clear how to handle payment for medical education. It should state that Medicaid Net Revenues should not include Direct Medical Education payments as those will be reported on Worksheet 5, but should include Indirect Medical Education payments. (Note: The Instructions will have to add that net revenues should be net of bad debt. The instruction is necessary because one accounting standard defines net revenues to include bad debt charges, while the other does not).

Issue: **"Persons Served" Is Undefined and Uncomparable.**

Because hospitals provide many different types of services, measurement of persons served is misleading and burdensome. First, hospitals would need a definition of persons served. Is it:

- Each time a person walks into the hospital?
- Each unique person in the community, regardless of how many times he/she visits the hospital during a specific year?
- Do a visit to the emergency department and then a visit to the radiology department count as two visits?
- Does an inpatient stay count as one person and an outpatient visit count as one person?
- What if the person has multiple payors or is dual eligible? Do they count under their primary payor only or do we count 1/2 people?

Some of the above are not possible for most current hospital systems to calculate. Even if clear definitions could be provided and the corresponding "persons" calculated, the final count is an unbalanced mix of inpatient and outpatient activity gives no comparable indicator of the size of the community benefit.

Recommended revision: Remove line 2. It is not a meaningful measure of community benefits.

Issue: **Define Disproportionate Share used in "Line 7. Unpaid Costs of Medicaid and Other Public Programs."**

Which definition of disproportionate share do you intend? A payment in the claims process that is based on the level of uninsured and Medicaid patients or funds from the States' limited DSH pool?

Recommended revision: This needs a rigorous definition if it is to generate comparable loss estimates.

Schedule H – Worksheet 4 (Community Health Improvement Services...)

Issue: **Worksheet 4 asks for burdensome data.**

This worksheet is fine as a guide to help hospitals calculate these costs, but is burdensome if it is required to be completed by hospitals. Hospitals may have internal systems that calculate or estimate these costs. Rigorous definitions of what counts as a Community Health Improvement Service and what does not will have to be provided in the instructions. To get comparable data, a team of IRS staff will have to field a constant stream of questions about what does and does not count. If hospitals find that it is too costly to fill this out, may they use estimates instead?

Recommended revision: Explicitly state in the directions that the worksheet is to be used as a guide and other cost estimate methodologies are allowed. Also give explicit instructions with criteria as to what counts and what does not. Hospitals will need a single body to judge whether an activity should be counted or not. Without one, answers will not be comparable. Also instructions should be explicit that expenses stated in here should be removed from total expenses in Worksheet 2 and these programs should not be double-counted in another category of community benefits (e.g. charity care, Subsidized Health Services, cash and in-kind donations).

Schedule H – Worksheet 5 (Net Cost of Health Professions Education)

Issue: **"Persons Served" Is Undefined and Incomparable.**

Because hospitals provide many different types of services, measurement of persons served is misleading and burdensome. First, hospitals would need a definition of persons served. Is it:

- Every student, even if they are part-time?
- Each FTE student?
- Hours taught?
- Classes taught?

Some of the above are not possible for most current hospital systems to calculate. Even if clear definitions could be provided and the corresponding "persons" calculated, the final count is an unbalanced mix of residents and other health professions and gives no comparable indicator of the size of the community benefit.

Recommended revision: Remove line "Number of Persons Served." It is not a meaningful measure of community benefits.

Issue: **How should Medicare exclusions impact this section?**

Medical education in hospitals is highly impacted by special Medicare treatment. Medicare has an allowed number of residents and allowed expenses.

As written, this section mixes Medicare terms with non-Medicare terms ("Line 3: Indirect Medical education costs") and would be impossible for providers to understand how to fill this out. The goal of the worksheet is to calculate the Net Costs of Health Professions Education provided by a healthcare organization. As written the form does not accomplish that.

Recommended revision: We recommend a simplified worksheet where the costs consist of the total costs to run the programs (These costs should be deducted from total expenses on Worksheet 2). The funding sources should be restricted to those explicitly labeled for medical education and not amounts reflected in generally higher reimbursement rates. For example Direct Medical Education Payments the hospital receives should count as revenues for these programs, but indirect payments should not (they should be left in Medicaid Net Revenues in Worksheet 3).

Issue: **What is Line 1C: "Direct Medical Education Cost" of "Community Programs"?**

Is this "all programs that educate the community" or "classroom programs that educate medical staff about community care" or something else?

Recommended revision: Explicitly define or delete this.

Issue: **What counts as a Health Professions Education Program?**

Does the program have to be accredited? If so by whom?

Recommended revision: Explicitly define this in the instructions.

Schedule H – Worksheet 6 (Net Cost of Subsidized Health Services)

Issue: **Single costing methodology leads to more comparable results.**

For the reasons outlined earlier in this letter:

- Differences in costing methodologies can produce a 20% difference in total costs estimates.
- At best, allowing multiple costing methodologies produces reports that cannot be compared fairly across hospitals. At worst, it will punish hospitals without the resources to review the differences in the methodologies.

Hospitals should not be given a choice on methods to calculate costs. Because most hospitals do not have a cost-based accounting system and there is no published research that all cost-based accounting systems calculate costs at the same level of accuracy, a single costing methodology should be the only allowed costing methodology. In this way, estimates are based on the same

methodology and are comparable.

Recommended revision: Eliminate "Method A: Cost accounting system" row.

Issue: **Lines 3-4 and 9-10: Inpatient and Outpatient breaks-outs are very difficult to provide.**

Within current financial systems, many hospitals are unable to break out either revenues or charges both by source and inpatient/outpatient status. In March of 2003 NCHA asked a sample of NC hospitals in a survey how difficult it would be to break out inpatient and outpatient charges by source (e.g. Medicare, Medicaid, Charity Care) and half responded that it was either not possible or very difficult for them to do so. A further refinement of splitting inpatient and outpatient by each subsidized hospital service would be incrementally more difficult. A community benefits report does not need this break out to calculate costs. It is extra information that would be burdensome for hospitals to provide and gives no benefit for the community benefit report.

Recommended revision: Combine lines 3-4 on Worksheet 6 into "Charges for Subsidized Health Services." Combine lines 9 & 10 on Worksheet 6 into "Net Revenues for Subsidized Health Services." (Note: The Instructions will have to add that net revenues should be net of bad debt. The instruction is necessary because one accounting standard defines net revenues to include bad debt charges, while the other does not).

Issue: **"Persons Served" Is Undefined and Incomparable.**

Because hospitals provide many different types of services, measurement of persons served is misleading and burdensome. First, hospitals would need a definition of persons served. Is it:

- Each time a person walks into the hospital?
- Each unique person in the community, regardless of how many times he/she visits the hospital during a specific year?
- Do a visit to the emergency department and then a visit to the radiology department count as two visits?
- Does an inpatient stay count as one person and an outpatient visit count as one person?
- What if the person has multiple payors or is dual eligible? Do they count under their primary payor only or do we count 1/2 people?

Some of the above are not possible for most current hospital systems to calculate. Even if clear definitions could be provided and the corresponding "persons" calculated, the final count is an unbalanced mix of inpatient and outpatient activity gives no comparable indicator of the size of the community benefit.

Recommended revision: Remove line 1. It is not a meaningful measure of community benefits.

Issue: **Calculation Steps in "Net Cost of Subsidized Health Services" Worksheet are unnecessarily cumbersome.**

The calculation asks for charges and costs for the each program's total, Medicaid, Charity Care populations. This misses other public programs category, which is on everything else. It also makes the calculation unnecessarily complicated by adding 11 extra, unnecessary calculations.

Recommended revision: This will produce the same result. Replace lines 2-7, all columns with a single column:

2. Total Program charge
3. Program's Medicaid Charge
4. Program's Charity Care Charge
5. Program's Other Public Program Charge
6. Net Program Charges (2 minus sum(3,4,5)
7. Total Expenses, net of Medicaid, charity care, and other public programs (* RCC or cost-based system)

Lines 9-12 can be similarly streamlined into one column:

9. Total Revenues for the program for all sources
10. Program's Medicaid reven
11. Program's revenues from Other Public Progra
12. Net Program Revenues (9 minus sum(10,11))

NOTE: You will have to specify whether revenues include or exclude Bad Debt for 10 and 11. Your answer should correlate with how you treat Bad Debt (as an expense and inclusion in revenues, as described in your current Worksheet 2, or not as an expense but rather a deduction from revenues, as described in IRS 990, Part V).

Schedule H – Worksheet 7 (Unsponsored Cost of Research)

Issue: **What is the definition of research?**

Does this mean unfunded clinical trials, or the research before clinical trials? Which sponsors are required to make the research eligible? Often patients will agree to be a part of a clinical trial where, for example, a company donates an implant for non-FDA approved use. Is this unsponsored research if the hospital implants it in the patient? (Should the entire patient visit count as a research cost?)

Recommended revision: All research and associated research costs should count as research. Count the research portions of patient care costs that were not reimbursed by the patient or his/her payor. Reduce total expenses in Worksheet 2 by total research costs and do not double count patients by putting them here and in another

community benefit category.

Issue: **Typo: Question 5a and 5b are a copy of 2a and 2b.**

Question 5 asks for research grants but the "a" and "b" parts of the question ask for expenses.

Recommended revision: Condense 5 into one number: Research Grants.

Schedule H – Other Comments

Issue: **Is it required that hospitals file all worksheets with this 990 and then does that make all of them public?**

Requiring hospitals to file their worksheets and, thereby, making them public records will be very burdensome for hospitals. The public will have little understanding of the intricate accounting methods used in these worksheets. Media access and reporting of data from these worksheets would further confuse the public.

Recommended revision: Do not require filing of worksheets or do not include the worksheets as part of the publicly available information. Describe in the instructions the IRS's intention concerning the worksheets.

Issue: **Where do physician recruitment and economic development go in Schedule H?**

Hospitals contribute to their communities in many ways, including helping with non-staff professional recruitment. Rural areas are especially vulnerable to losing physicians. Hospitals are expected to help recruit new community physicians. Last year the average rural hospital expense for physician recruitment doubled to over $140,000. These expenses are expected to grow for the foreseeable future. Since these are not staff physician positions, these are community expenses and should count as such. They do in many other community benefit reports.

Economic development is an important expense for hospitals these days. Communities rely on their hospitals to help foot the bill of inducement money for encouraging other industries to re-locate to the community. These expenses are clearly a community benefit. If the IRS wishes to have hospitals roll these expenses in with cash donations, it should explicitly list them in the instructions.

Recommended revision: Add categories in Part I – Other Benefits section for each of these.

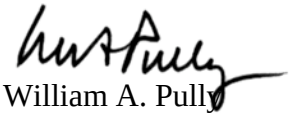
Issue:	**Where should hospitals include in Schedule H those community benefit items that are difficult-to-measure?** Not all community benefits are easily quantifiable. For example, the mere presence of the hospital means the community's life is better. More folks live because they have prompt access to healthcare and, for rural areas, it is a key factor in the decision of business relocation. The hospital provides both direct and indirect jobs to the community. There are many more aspects to each community benefit program than numbers can provide. Hospitals should have a place on the Schedule to describe community benefits that do not fit into any of the above categories or are difficult to measure.
Recommended revision:	Allow hospitals an "Other" section where they can describe and quantify, where possible, any other community benefits not otherwise covered.

Several items remain unclear on both the Form and the schedules. These items are noted among the more than 50 comments outlined by the American Hospital Association in its comment letter. Until these issues are clarified, hospitals remain unclear how to fully comply with the proposed Form 990 requirements.

Thank you for your consideration of these issues. We welcome questions about our comments and will be eager to assist further with this important matter.

Sincerely,

NORTH CAROLINA HOSPITAL ASSOCIATION



William A. Pully
President

Appendix A – Summary of Comments by Section

From:	David McClure
To:	*TE/GE-EO-F990-Revision;
CC:	Michelle Long;
Subject:	Comments on Redesign of 990
Date:	Thursday, September 13, 2007 9:39:31 AM
Attachments:	Final Comment Letter on IRS Form 990 9-12-07.pdf

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The Tennessee Hospital Association (THA), on behalf of its more than 200 healthcare facilities, including hospitals, skilled nursing facilities, home care agencies, nursing homes, and health-related agencies and businesses, and over 2,000 employees of member healthcare institutions, such as administrators, board members, nurses and many other healthcare professionals, appreciates the opportunity to submit the attached comments on the new draft Schedule H to Form 990.

David McClure
Vice President of Finance
Tennessee Hospital Association
500 Interstate Blvd South
Nashville, TN 37210
Direct phone: 615-401-7465
Toll free: 800-258-9541
Fax: 615-242-4803

September 12, 2007

Internal Revenue Service
Form 990 Redesign, SE:T:EO
1111 Constitution Avenue, NW
Washington, DC 20224

RE: Comments on Proposed 990 - Schedule H

The Tennessee Hospital Association (THA), on behalf of its more than 200 healthcare facilities, including hospitals, skilled nursing facilities, home care agencies, nursing homes, and health-related agencies and businesses, and over 2,000 employees of member healthcare institutions, such as administrators, board members, nurses and many other healthcare professionals, appreciates the opportunity to submit comments on the new draft Schedule H to Form 990.

We appreciate the work the Internal Revenue Service (IRS) has put into the new form and schedules and its solicitation of the hospital community in the early stages of the design of these forms. We understand the IRS may have several rounds of changes as the comments are considered, and we appreciate the opportunity to be involved in that process. At this time, we have some concerns about Schedule H, including its failure to capture the fullness of community benefit provided by tax-exempt hospitals.

Tennessee hospitals support the community benefit standard, which requires the promotion of health in accordance with community needs in the absence of private benefit. An IRS form that will be used to determine a threshold of community benefit required for income tax exemption should be designed to generate as much information as possible so the activities and programs of these hospitals can continue. Based on our initial reviews, we have four primary concerns with Schedule H that we are asking the IRS to address:

- Additional time and instruction is needed to prepare for the use of this form.
- Community benefit should be broadly defined to capture all of an organization's activities.
- An accurate picture of a healthcare organization requires further classification.
- Information unrelated to community benefit should be removed.

IMPLEMENATION OF SCHEDULE H SHOULD BE DELAYED UNTIL 2010 TO ACCOMMODATE THE DELAY THE IRS ANTICIPATES IN ISSUING INSTRUCTIONS, AS WELL AS THE NEED TO ADJUST OR CREATE SYSTEMS TO CAPTURE THE REQUIRED FINANCIAL INFORMATION.

Tennessee hospitals are committed to transparency. In 1989, the Catholic Hospital Association introduced the Guide for Planning and Reporting Community Benefit. Since

that time, approximately half of the nation's hospitals have migrated to the use of this format for the collection of community benefit information. Prior to this draft Schedule H, tax-exempt filers have included community benefit in various formats, as supporting documentation with their Form 990.

In order to capture the amount of data required to complete Schedule H, financial and data recordkeeping systems will need evaluation, and most likely, reconfiguration – a task which cannot be accomplished by Jan. 1, 2008. The task is made impossible by the fact that the instructions, definitions and worksheets needed to collect that data are not expected to be finalized until mid-2008. To require hospitals to file this form without the benefit of instructions, worksheets and definitions is by itself unreasonable. Coupled with the overhaul of financial and recordkeeping systems to extrapolate the data, it makes the filing deadline both unreasonable and needlessly disruptive. We urge the IRS to consider providing a second draft of this form when the supporting information is available and provide another comment period toward the goal of finalizing Schedule H for fiscal years beginning after Dec. 31, 2008.

Revenue Ruling 69-545 recognized a variety of factors are the pillars of the "community benefit" standard. Those same factors are reflected in the form hospitals use to apply for tax exemption: Form 1023, Application for Recognition of Tax Exempt Status, Schedule C. In addition, it is a concern that Schedule H does not incorporate that same focus and inquire about those factors in seeking to determine compliance. At the very least, this inconsistency could unfairly increase the likelihood of a hospital being subjected to an IRS audit.

THE FULL VALUE OF THE COMMUNITY BENEFITS HOSPITALS PROVIDE SHOULD BE INCLUDED IN SCHEDULE H.

Hospitals qualify for tax exemption by promoting health in accordance with the needs of a community in the absence of private benefit. For almost 40 years, the community benefit standard, set forth in Revenue Ruling 69-545, has been the standard used by the IRS, the courts and the tax-exempt community in determining tax-exemption for hospitals and healthcare organizations. The community benefit standard permits a hospital to go beyond what is thought to be traditional healthcare to tailor its programs and services to meet specific community needs. Among these needs is providing care for elderly Medicare patients, low income patients and patients in need of emergency care who may not be able to afford the costs of that care. Yet hospitals open their doors to the community and absorb the costs of doing so, which should be reflected in any tool designed to quantify community benefit.

Medicare underpayments are community benefit.

Part I "Community Benefit Report" in draft Schedule H allows hospitals to report and receive community benefit credit for Medicaid and other government program underpayments, but not Medicare underpayments. Medicare, like Medicaid, does not pay the full cost of care. Many Medicare beneficiaries, like their Medicaid counterparts, are poor. THA urges the IRS to consider including Medicare underpayments in community benefits.

Serving Medicare patients is part of the community benefit standard. Medicare, like Medicaid, does not pay the full cost of patient care. As a result, hospitals and the communities they serve absorb these underpayments. Currently, Medicare reimburses

hospitals 92 cents for every dollar spent on care. The Medicare Payment Advisory Commission (MedPAC) in its March 2007 report to Congress cautioned that the situation will get even worse, with margins reaching a 10-year low at negative 5.4 percent. Moreover, an increasing number of Medicare beneficiaries also are low-income. More than 46 percent of Medicare spending is for beneficiaries whose income is below 200 percent of the federal poverty level. Medicare underpayments represent a real cost of serving members of hospital communities and should be counted as community benefit.

The cost of patient bad debt is community benefit.
As currently drafted, Schedule H does not count patient care bad debt expenses as community benefit. A significant amount of bad debt is attributable to low-income patients, who upon admission, fail to complete the forms required or provide the information necessary to establish eligibility to access hospital charity care or financial assistance programs. Preadmission or early admission screening for eligibility requires significant staff resources. To reduce overall cost, many hospitals classify the expense as bad debt rather than charity.

A 2006 Congressional Budget Office report cited two studies indicating "the great majority of bad debt was attributable to patients with incomes below 200 percent of the federal poverty level." The fact is that despite our best efforts, many patients still do not identify themselves as in need of financial assistance. It is important to the communities served by our tax-exempt hospitals that the full cost of serving the community – including the cost of serving patients who need help paying their bill, but fail to ask for it – be recognized and counted as community benefit.

Services through the emergency department are community benefit.
Hospitals provide an enormous amount of care through the emergency department. As such, hospitals routinely serve patients, without regard to ability to pay, some of which is compensated, but the majority of which is absorbed by the hospital. Since 1969, the IRS has held that "by operating an emergency room open to all persons and providing hospital care for all those persons in the community all to pay the cost thereof either directly or through third party reimbursement," a hospital is promoting the health of its community in a broad enough manner that it is deemed "community benefit." Emergency care is a service that no community should be without and, as such, it should be counted as community benefit.

Research activity by hospitals should be included in community benefit.
While it may not fit within the traditional notion of community benefit, hospitals that are engaged in a significant amount of research that they disseminate and use at their own expense to impact the world community should be counted as community benefit. For example, Tennessee is home to hospital with a mission to improve survival rates for children and adolescents with catastrophic illnesses worldwide, through the sharing of knowledge, technology and organizational skills. Currently, the hospital has collaborative relationships with sixteen (16) other countries. Consideration of this and other research activity by hospitals, in the absence of profit, falls squarely within the qualifications for tax exemption and should be reflected on the IRS forms.

AN ACCURATE PICTURE OF A HEALTHCARE ORGANIZATION REQUIRES FURTHER CLASSIFICATION.
The inclusion of language designating the type of hospital reporting provides an important context for the data collected. THA urges the IRS to add a section with checkboxes allowing the filing organization to indicate the type of facility making the

report. For consistency and because of their industry-wide recognition, the same definitions used in Medicare cost reports should be used, i.e. Children's Hospital, Critical Access Hospital, Research Hospital, Rural Hospital, Sole Community Hospital, Teaching Hospital, and Urban Hospital. Moreover, in adopting a definition of "hospital" generally, THA urges the IRS to adopt the Medicare cost report definition of hospital.

INFORMATION UNRELATED TO COMMUNITY BENEFIT SHOULD BE REMOVED.

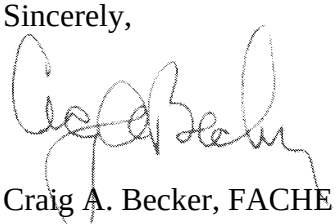
The proposed chart on Schedule H, Part II relating to billing should be eliminated. It goes beyond the elements of the community benefit test by requiring specific billing information by categories of healthcare coverage as follows: 1) Medicaid; 2) Medicare; 3) other governmental programs; 4) private insurance; and 5) uninsured. This information has no bearing on community benefit, and may result in free discovery for lawyers seeking to challenge an organization's charity care and billing practices.

SUPPORTING WORKSHEETS SHOULD BE INCORPORATED INTO THE SCHEDULE AND SUPPORTING INSTRUCTIONS CLARIFIED

In the instructions for Schedule H, Worksheet, which provides a computation of charity care provided by the facility, the net philanthropic contributions and payments from uncompensated care pools are netted against charity before reporting on the Schedule H. THA believes the information requested and method reported is presented in a misleading and/or overly abbreviated manner that would confuse instead of inform reviewers. THA recommends the full amount of charity provided be disclosed on the filed forms. THA also recommends the definition of philanthropy (restricted versus unrestricted) be clarified and the instructions for health professions' education be clarified.

Again, THA appreciates the opportunity to submit comments at this early stage in the development of Schedule H. If you have any further questions or need any additional information on how the revisions to Form 990 and its schedules will impact the hospital community, please do not hesitate to contact THA at 615-256-8240.

Sincerely,



Craig A. Becker, FACHE
President

cc: Tennessee Congressional Delegation
Rick Pollack, AHA, Executive Vice President

From:	Hollenbeck, Ann T.
To:	*TE/GE-EO-F990-Revision;
CC:	WisnerC@trinity-health.org;
Subject:	Comments on Redesigned Draft Form 990
Date:	Wednesday, September 12, 2007 7:23:46 PM
Attachments:	TaskForceForm990Letter.pdf

Attached please find comments on the Redesigned Draft Form 990.

Ann T. Hollenbeck
Honigman Miller Schwartz and Cohn LLP
2290 First National Building
660 Woodward Avenue
Detroit, MI 48226-3583
313.465.7680
fax: 313.465.7681

HEALTH CARE LAW SECTION

September 12, 2007

Internal Revenue Service
Form 990 Redesign, SE:T:EO
1111 Constitution Avenue, NW
Washington, D.C. 20224

Re: COMMENTS ON DRAFT REDESIGNED FORM 990

On behalf of the Health Care Law Section of the State Bar of Michigan, thank you for the opportunity to comment on the redesigned Form 990. We appreciate the work that the IRS has put into the new form and schedules and its openness to comments from the healthcare community. We believe that the redesign is an important and valuable project and urge the IRS to invest the time to ensure both the form and instructions are in order for complete, accurate and understandable reporting.

Our Task Force, the members of which are listed on Exhibit A of this letter, respectfully submits the following comments for your consideration.

1. **General Comments**: Implementation of the redesigned Form 990 should be delayed until 2010 to accommodate the delay the IRS anticipates in issuing instructions, as well as to allow filers additional time to adjust or create systems to capture the required financial information. The delay is not requested to delay transparency and open reporting of the activities of tax-exempt entities, but instead in recognition of the burden of creating or re-configuring financial and data recordkeeping systems in time to capture the substantial amount of data required.

Some of this data is not currently collected for financial reporting or financial auditing purposes. For example, the data collection just for the Part I Community Benefit Report by January 1, 2008, is itself a daunting task. The collection task is more difficult due to the fact that the final instructions, definitions and worksheets needed to collect that data are not expected to be finalized until mid-2008. To require hospitals to overhaul financial and data recordkeeping systems before the definitions, line item instructions and worksheets for making the calculations required for Schedules H and K are completed is unreasonably costly and disruptive. The new calculations and extrapolations typically have not been included previously in financial statements. Further, the methodology for the data integrity and reporting has not been finalized and requiring reporting too soon may lead to public dissatisfaction. The significant number of members of the public and oversight agencies who likely

will rely on the reports compels care to provide for consistency in reporting. It is in the best interests of both the IRS and the tax-exempt community to ensure that inaccurate perceptions of the activities of tax-exempt entities are not created by reporting formats that are not clearly and consistently applied. To ensure the best reporting of useful information for review by both the IRS and the public, a minimal delay is necessary to complete instructions and provide sufficient time for systems to be re-configured for data collection and calculations.

Given the number of questions and concerns about Schedules H and K that have surfaced, we would urge the IRS to consider providing second drafts in 2008 and another review period toward the goal of finalizing these schedules by December 31, 2008, with the new Form 990 implemented for the 2010 tax year (i.e., tax years beginning on or after January 1, 2010). Second drafts of the Form and Schedules and delayed implementation would give hospitals sufficient time to revise their financial and data recordkeeping systems in order to track and capture new information that will need to be reported.

The IRS also invited comments on whether it should continue to allow group returns. It is our view that if exemption is granted to a group of entities, then a return should be filed for the group that was granted the tax-exemption in order to reflect and permit oversight of the group.

2. **Core Form 990.**

(a) In Part II, Section A, Column A, the revised form requires that we list the City and State of residence for all board members listed in this schedule. As with the current Form 990, we believe that the organizational address should still be an option for reporting. Using the City/State of personal residence can create risk to board members, such as risk of identity theft, unwelcome commercial use of addresses or other adverse issues. Given that many board assignments are voluntary this disclosure requirement could be a deterrent for board member service.

(b) The placement of Part IX as the last part of the core Form 990 is misleading. The statement of program services in this Part is the only place in the form where an organization can describe in some detail its tax-exempt purpose and the community benefits provided by the organization. By placing it on the last page of the form, following all the questions related to potential noncompliance, it appears that the main purpose for exemption is an afterthought to compliance issues. We believe this statement should be in Part II of the Form 990, and should come immediately after the summary section on page one.

3. **Schedule D: Supplemental Financial Statements:** Part VII. This part of the form asks for the footnote disclosure, from the financial statements, related to FIN 48 (i.e. any uncertain income tax positions). This question should be removed or modified for four reasons. First, it can be misleading to take certain

footnotes from the audited financial statements and put them in the information return. Audited footnotes must always be reviewed in the context of the full set of audited financial statements – in fact, independent auditors advise clients and readers of financial statements not to take information out of context, and specifically disclaim responsibility for such use. The IRS should not encourage such use of information out of context. Second, many tax-exempt organizations do not undergo formal audits. Thus, a footnote in this regard may not exist. As such, this question should be broken into two parts. Part I should ask whether the organization has audited financial statements and if the answer is yes, then Part II should ask for the disclosure. Third, a common method for resolving uncertain income tax positions before a FIN 48 disclosure becomes necessary is seeking a private letter ruling. The IRS, however, has adopted a "no rule" position on several issues, including the tax effects of nonprofit/for-profit joint ventures and other issues which may be inextricably intertwined with the FIN 48 disclosure. Accordingly, the Form 990 should either eliminate required disclosure of the FIN 48 footnote entirely or at least exclude any FIN 48 footnote that relates to any "no rule" issues. If the IRS subsequently revises its "no rule" list, out of fairness in tax administration the IRS should allow a grace period for organizations to submit requests for private letter rulings on those issues for completed transactions or require disclosure of the FIN 48 footnotes related to those issues on a prospective basis only (i.e., for transactions entered into after such modification of the "no rule" issues list). Finally, many tax-exempt organizations will not have FIN 48 issues, especially in the absence of UBI. The absence of FIN 48 issues may give rise to concern on the part of a reader when it should not. We recommend that the IRS reconsider requiring the reporting of footnotes written for financial statement audit purposes.

4. **Schedule F: Statement of Activities Outside the U.S.**: The IRS has stated in commentary that it does not view Schedule F as requiring disclosure about the activities of a tax-exempt organization's subsidiaries. Many tax-exempt hospitals have formed off-shore captive insurance companies for purposes of self-insurance and are concerned that Schedule F could be read to require reporting subsidiary activities on the schedule. We would ask that the IRS clarify in instructions to Schedule F that tax-exempt entities are not required to report information on the activities of their subsidiaries on this Schedule, including their off-shore subsidiaries.

5. **Schedule H: Hospitals:**

(a) One question arising in the interest of improved transparency is whether the new Schedule H should be filed on a "facility by facility" basis with all of the Schedules attached to a single Form 990 filed by the exempt organization, by EIN or on an aggregate basis. Some commenters have expressed concerns that without a breakdown by facility there would be an incentive to reorganize hospitals into larger groups to improve the appearance of the charity care and community benefit numbers on Schedule H and that reporting by facility rather than on a consolidated

basis is necessary to be able to compare hospitals on an apples-to-apples basis. Although including a summary page that would aggregate individual numbers may provide a picture of the whole filing organization's performance, the separate schedules have the potential to mislead and serve no useful tax administration purpose. The IRS should bear in mind that the Form 990 is first and foremost intended to provide information to the IRS, and such information also is available to the public and used for other oversight purposes.

Bearing these purposes in mind, the answer to the question of how to file Schedule H seems self-evident. The schedule should be filed the same way the Form 1023 or other exemption application was filed- based on the activities of the tax-exempt entity, not facilities within the entity. For each individual determination letter, the tax-exempt entity should file the Form 990 (including Schedule H), whether the entity with the determination letter represents one or multiple facilities. It would serve no purpose relevant to federal income tax laws to compile charity care and community benefit data on the basis of any unit other than the tax-exempt entity that was granted exemption. The exemption standards apply to the tax-exempt entity as a whole, not to individual facilities, departments or rooms. It is also overly simplistic to suggest that nonprofit hospitals would incur the substantial additional costs and inconvenience of massive reorganizations simply to improve their numbers on Schedule H. Reorganizations are expensive propositions and involve not only extensive due diligence, but also often a variety of state and federal approvals.

(b) The Task Force believes that the full value of the benefits hospitals provide should be included in Schedule H, not just a report of dollars spent on a limited number of activities in furtherance of exempt purposes. Hospitals qualify for exemption as organizations described in Section 501(c)(3) by being organized and operated for the charitable purpose of promoting the health of the community consistent with the community benefit standard. The community benefit standard permits hospitals to tailor their programs and services to the needs of their individual communities. Among those community needs is often care for all patients, including Medicaid and Medicare patients, veterans, insured and underinsured patients, uninsured patients and low-income patients, any and all of whom may not be able to afford the costs of their care. The costs incurred in providing care to all members of the communities served should be reflected as a community benefit on Schedule H

(i) Part I "Community Benefit Report" in draft Schedule H allows hospitals to report and receive community benefit credit for Medicaid and other government program underpayments, but not for Medicare underpayments. We believe Medicare underpayments should be reported and made known just as underpayment of costs for other services should be included in

reporting the benefits by the tax-exempt entity to the communities served. While there is a difference of opinion in the healthcare industry over whether or not Medicare shortfalls should count as charity care or community benefit, Rev. Rul. 69-545, 1969-2 C.B. 117, clearly indicates that serving a Medicare population is part of satisfying the community benefit standard. Moreover, in numerous rulings in the long-term care area, the IRS has recognized the special needs of the elderly as a class (the typical Medicare beneficiaries). See, e.g., Rev. Rul. 72-124, 1972-1 C.B. 145; Rev. Rul. 79-18, 1979-1 C.B. 194. The Form 990 is not the appropriate place to change the law on what constitutes a community benefit. To accommodate the different views in the industry and allow for a more transparent comparison of hospitals, and avoid an inappropriate change in law through a new information return, we recommend that Schedule H clearly include the reporting of Medicare shortfalls as one category of community benefit--reported separately from Medicaid shortfalls and other uncompensated care for better transparency. We believe this additional reporting will provide useful information in comparing hospitals, and avoid disadvantaging those hospitals that are compelled to operate in higher cost environments (e.g., union workforce, higher cost of living, added local tax burdens) or have more lower margin services or provide money losing services to Medicare beneficiaries.

(ii) The cost of patient bad debt also is community benefit as it reflects the shortfall between the care provided and the funds collected to cover the costs of such care. As currently drafted, Schedule H does not count patient care bad debt expenses as community benefit. We know that a significant majority of bad debt is attributable to low-income patients, who for many reasons decline to complete the forms required to establish eligibility for hospital charity care programs. A 2006 Congressional Budget Office report cited two studies indicating that "the great majority of bad debt was attributable to patients with incomes below 200 percent of the federal poverty level." Many patients do not identify themselves as in need of financial assistance. Patients are often unable to timely provide information about their circumstances, and nonprofit hospitals do not delay care to financially prescreen patients. Hospitals do not have resources to pursue individual assessments of patients who are without means and who decline to participate in the charity care classification process at the time of service. The primary goal of these patients and hospitals is timely and appropriate health care. Hospitals may obtain information at a later date that demonstrates that the patient would have been eligible for charity care, and thus the distinction between "bad debt" and charity care can be artificial. The full cost

of serving communities (including the cost of serving patients who need help paying their bill but fail to ask for it) should be recognized and counted as community benefit.

(iii) Schedule H needs to be streamlined to eliminate questions that are burdensome and confusing, and that fail to provide meaningful information to the community. For example, the proposed chart on Schedule H, Part II relating to billing should be eliminated. This chart has no bearing on determining whether a hospital is meeting the community benefit standard, and it should not be used to create new reporting standards. Relevant information is already provided in other parts of the Form 990. Detailed information on charity care will be provided in Part I of Schedule H. Information related to a hospital's revenues and Medicare and Medicaid payments will be included in Core Form 990. Beyond that, the chart's added layers of requests for information are burdensome and will require additional staff work to provide. Some of the information requested is competitively sensitive (e.g., Chargemaster rates, cost-to-charges ratios and third party payor discounts). Further, the chart may be confusing to the public and is not reflective of the community benefits provided or value of the tax-exempt entity to the community.

(iv) Additional information of importance to the IRS and the public would be information about the needs of the specific communities served. We recommend that Schedule H, Part IV, Question 4 be expanded (and made more prominent (by moving it up in Schedule H to Part I or adding another schedule) to more clearly capture information about the communities being served and the activities and services provided to benefit those communities.

(c) There has been some confusion as to which organizations constitute hospitals for purpose of Schedule H. For example, as written it could be viewed as requiring this report for faculty practice plans, even though the basis for their exemption typically relies more heavily on educational purposes or medical research than on the traditional community benefit purposes of nonprofit hospitals. The same can be said for many teaching hospitals. Likewise, Schedule H may be read to include clinics that are exempt as an integral part of an umbrella hospital system. Those clinics may have no separate hospital beds and operate subject to overall hospital policies. Moreover, although a growing number of states (as well as some views of good governance practice) require some form of community benefit reports for hospitals, they typically do not extend to nonprofit groups providing other types of health care services.

Although many of the questions may improve transparency for typical acute care hospitals, they are in large part not relevant to educational and research-focused organizations and organizations performing a supporting role in a larger health care system. We recommend that the IRS clarify that Schedule H applies only to organizations licensed as hospitals under state law, and only if their primary purpose is not some combination of education and medical research.

(d) It is unclear what information the IRS is seeking pursuant to Part III of Schedule H in connection with hospitals. As a general matter the information on Part III appears to be repetitive to Schedule R and the instructions for providing data. In addition, reporting related to joint ventures is vague and could easily confuse tax-exempt entities leading to inaccurate, and in the worst case, misleading reports.

We suggest that the IRS clarify the schedule to capture information for the purpose of overseeing the limitations related to disqualified persons. Further, information should not be requested or collected as to all physicians as not all physicians meet the statutory definition of "disqualified persons."

We also believe it would promote transparency by asking the same universe of questions regarding joint ventures of all exempt organizations. To that end, Schedule H, Part III should be moved to a different schedule and should be completed by all tax-exempt entities participating in such joint ventures or management contracts, or at least all 501(c)(3) and (c)(4) organizations that are subject to the excess benefit rules of Section 4958 and potentially other organizations subject to an inurement prohibition (i.e., 501(c)(6), (7), (9), (11), (13), (19) & (26)).

6. **Schedule K: Supplemental Information on Tax-Exempt Bonds:**

(a) Schedule K and other parts of the Form 990 request information that not only has little, if any, relevant tax significance, but also exceeds any reasonable recordkeeping expectations. Part III of Schedule K requires detailed information regarding private use of bond-financed facilities, including: whether the filing organization was a general partner, managing member or held more than a 50% profits interest in a partnership or LLC that owned property financed by tax-exempt bonds; any management contract for the facility and whether it met the safe harbor (Rev. Proc. 93-17, 1997-1 C.B. 632); any research contract involving the facility and whether it met the safe harbor (Rev. Proc. 2007-47, 2007-29 I.R.B. 108, superseding Rev. Proc. 97-14, 1997-1 C.B. 634); and the highest percentage of the project subject to a management or research contract. The requirement to report percentage of use, however, is not limited to arrangements outside of the safe harbors, rather it also includes contracts that are deemed not to constitute private use by virtue of

the safe harbors. In light of the scope of the safe harbors, the percentage of use of protected contracts is wholly irrelevant for enforcement purposes. It is also information that is not likely to have been tracked by any tax-exempt hospitals to date insofar as the percentage of use reflected by contracts within the safe harbor was beyond the scope of any recordkeeping requirements and of no tax significance whatsoever. It also would be misleading to the public to report use pursuant to contracts that are within the Rev. Proc. 97-13 or other safe harbors or that relate in whole to services provided for the facility that otherwise do not constitute private business use of the facility.

(b) Schedule K also requires reporting any other private use; and the highest percentage of that other private use. The level of due diligence each year that will be necessary to fully and accurately answer these questions will be significant, essentially requiring a self-audit of private use annually for each individual bond issue. We urge the IRS to consider these significant added costs for the charitable sector in deciding what information is truly essential for enforcement purposes on the Form 990.

(c) In the case of bonds that have been refunded several times, a significant portion of time may have elapsed since the original expenditures were made. Based on the historical record retention procedures of the various issuers, some entities likely will have a very difficult time retrieving and identifying the financed property information requested in Parts I and II, particularly the variety of information not expressly required to be collected on an ongoing basis in the past. We suggest that the information required should be limited to bonds issued after final instructions are released. Even those tax-exempt entities that have begun internal bond compliance programs have focused on bond issues from 1997 forward based on the IRS's bond compliance project guidance.

(d) Question 4 of Part III asks for the highest percentage of the project that was subject to a management contract or a research agreement. This question does not assist the IRS in determining if the project was compliant with the IRS' private business use regulations. The management contracts or research agreements at issue may fit within a safe harbor. Additionally, some bond counsel have interpreted certain uses as not constituting a private business use even though a contract or agreement does not fall strictly within a safe harbor.

Requiring filers to calculate this percentage would basically require them to provide information that is not legally relevant to determine whether an issue meets the private business use test.

At most, Question 4 in Part III should only be required to be completed only if the answer to either Question 2b or 3b in Part III is answered "no".

Additionally, a filer who receives an opinion from outside bond counsel that a management contract or a research agreement does not satisfy one of the safe harbors, but still would not constitute a private business use should also be able to exclude the use under that contract or agreement from the percentage requested in response to Question 4. Finally, Question 4 should be refined to ask for the percentage of the project that was subject to a private business use during the reporting period, not all uses pursuant to management or research contracts.

(e) Although there are other types of uses that do constitute a private business use (i.e., use constituting an unrelated business activity, leased space), Question 5a of Part III is overbroad in that there may be some uses by an entity that would not constitute a private business use (i.e., clinical research agreements). As with the comment to Question 4, a filer that has already begun a bond compliance program may not track this information because it is irrelevant to determining whether any given issue satisfies the private business use test.

7. **Schedule M: Non-Cash Contributions**: We question the need for the information requested on Schedule M for non-cash donations that are not material. Therefore, we suggest that Schedule M be limited to organizations with annual non-cash donations in excess of 50% of the aggregate of all donations, or limited to industries where there is a demonstrated potential for abuse (e.g., used car donation programs). In addition, we suggest that Line 10 be deleted because the value of any publicly-traded security is readily determined under existing IRS rules and not subject to manipulation.

8. **Schedule N: Liquidation, Termination, Dissolution or Significant Disposition of Assets**: Schedule N does not differentiate between transfer to for-profits and tax-exempt Section 501(c)(3) organizations. We believe that this is an important distinction that should be provided on Schedule N. Schedule N requires disclosure of the details of defeasance, discharge or settlement of tax-exempt bond obligations related to a liquidation, termination or dissolution of the issuer or conduit borrower filing the Form 990. As drafted, Schedule N fails to take into account that transferring assets to another Section 501(c)(3) organization with similar operations or a state or local governmental entity may avoid the need for any defeasance. See Treas. Reg. §§ 1.145-2(a) & 1.141-12.

9. **Schedule R: Related Organizations:** We recommend that inter-company transactions be explicitly excluded from disclosure on Schedule R, so long as they meet the following three requirements (a) the transaction is with another tax-exempt organization; (b) such tax-exempt organization is wholly-owned by, or a sister organization to, the filer; and (c) the transaction does not give rise to unrelated business income.

* * * * *

On behalf of the Redesigned Form 990 Task Force, we thank you for the opportunity to comment on the redesigned Form 990. In addition to these substantive comments, we have set forth on Exhibit B to this letter our technical comments and questions on the redesigned Form 990. Should you wish to communicate with our Task Force, please contact either of the Co-Chairs of the Task Force, where noted below.

Sincerely,

Ann T. Hollenbeck /bpd

Ann T. Hollenbeck
Co-Chair, Form 990 Task Force
ahollenbeck@honigman.com

Cynthia F. Wisner /bpd

Cynthia F. Wisner
Co-Chair, Form 990 Task Force
wisnerc@trinity-health.org

HEALTH CARE LAW SECTION

EXHIBIT A

State Bar of Michigan
Health Care Law Section

Redesigned Form 990 Task Force Members

CO-CHAIRS

Ann T. Hollenbeck
Cynthia F. Wisner

MEMBERS

Michele Ekblad
Gerald M. Griffith
Kathy Kudner
Mark R. Lezotte
David M. Leonard
Veronica Marsich
Kirk W. Morgan
Josh Moore
Donna A. O'Connor
Gail Pabarue
Y. Marie Paratto
Mike Philbrick
Ryan J. Powers
Christian Schafer
Sarah Slosberg Tayter
Michael P. Vecchioni

EXHIBIT B

State Bar of Michigan
Health Care Law Section

Technical Questions on Form 990 and Schedules

Core Form – Part I - Summary

Question 3. Should "number of board members" relate to the number at a specific point in time, for example, year-end, or should it relate to the number of individuals that may have served on the board during any part of the year? Please clarify.

Question 5. This question asks the organization for its number of employees. We understand that this question is already included in the current Form 990 (Line 90b). We are hopeful that the new Form 990 will provide an opportunity for the IRS to explain whether volunteers should be included in the reported figure or whether the number of volunteers should be an item that is reported elsewhere in the Form 990.

Core Form - Part II - Section A

This section of the return requires that the organization disclose the compensation of officers, directors, trustees and key employees using W-2 information. However, as with the current process, filers should have the choice to use either calendar year or fiscal year compensation information if the organization is a fiscal year filer to ensure the figures on the Form 990 encompass the period being reported. To avoid abuse of switching reporting periods to hide compensation, an organization could be required to select either a calendar year or fiscal year basis for reporting and then require IRS approval to change (as with certain changes in accounting methods). The heading for the table also should clearly reflect this election and the period covered by the report as required fields.

Core Form – Part III - Statements Regarding Governance, Management and Financial Reporting

Question 2. The IRS leaves the definition of the term "significant" up to the filer. The current Form 990 asks filers whether governing document changes were sent to the IRS without a need for further explanation. This redesigned form asks for an explanation of the changes in a very small section of the return. The changes to governing documents should be seen in the context of the entire document rather than excerpts included in the Form 990; and, as such, this explanatory section should be removed.

Question 3b. What is the relevance of this question? Will the answer subject an organization to review by the IRS?

Question 7b. This question should be clarified by adding a specific definition of "chapter, branch or affiliate." We assume the intent is to include only local groupings chartered or created and controlled by the filing organization. If, however, the intent is broader (given use of "affiliates"), it may provide confusing and unhelpful information where the organization has only loose contractual affiliations and no ability to control. In those situations, a "No" answer would create an unfair negative perception of how the filing organization is run.

Question 8. An individual does not "prepare" the organization's financial statements for larger organizations. The entire finance department prepares the financial statements. The question should be reworded to identify the person responsible for the accuracy of the financial statements.

Question 9. Some organizations use the finance committee to function as both finance and audit committees. Thus, this question should ask if the organization has an audit or other committee (such as finance) that functions as an audit committee.

Core Form – Part IV – Statement of Revenue

Line 1g requests "non-cash" amounts provided to the organization. Does this include donated services? Schedule M refers to non-cash contribution of "assets" but whether donated services constitute an "asset" should be specified. Also, does this Line 1g include intangible assets such as donated software rights or other such items which might constitute donations of intangible rights? Please clarify.

Line 10a-d. Lines 10a-c asks questions related to sale of assets other than inventory. Line 10d summarizes the disclosure by subtotaling the previous lines, however, Line 10d is written to define the subtotal as "gain/loss from investments". This is misleading since Lines 10a-c can be gains/losses from sales other than investments. Please clarify.

The instructions for Line 13 state the organization is to individually list the top three sources, and report as one lump sum, the remaining miscellaneous revenue. By the term "sources" is the IRS referring to types of activities, specific payor organizations, or other? Please clarify.

Core Form – Part V – Statement of Functional Expense

Line 4 references compensation of "officer," which is defined too broadly in the applicable glossary. This term should be more narrowly defined so as not to include persons who simply carry out Board directives, but are not officers.

Is Line 8 intended to include pension plan contributions only for employees who are not directors, officers or key employees (with those contributions related to directors, officers or key employees being reported on Lines 5 and 6)? The instructions are unclear. More clarity with respect to the reporting of Lines 5, 6, 7, 8 and 9 is requested.

Core Form – Part VII – Statements Regarding General Activities

Line 3 asks whether the organization provides credit counseling, debt management and related services. The instructions indicate that this includes educating and/or counseling consumers. Presumably when a hospital educates a patient as to his or her payment options for hospital services, charity care policies, or works with a present or past patient in restructuring his or her debt to the hospital (including subsequent collections activities), such activities do not fall within the scope of this question. Please confirm.

In Line 16 the form references the term "permanent endowments". However, Schedule D references the term "endowments". Please clarify as it appears the question and schedule are inconsistent.

Core Form - Part VIII – Statements Regarding Other IRS Filings

For purposes of Line 1, additional guidance as to what constitutes "indirect" political campaign activities on behalf of a political candidate would be helpful.

Core Form – Part X – Signature Block

In using a third party designee we are concerned about the public access to the designees' personal identification number. The third party designees' PIN request should be removed from the form.

Schedule B – Schedule of Contributors

There is still confusion as to whether Schedule B should be prepared on a cash or accrual basis. The instructions should make this point clear. Given that Schedule B follows the schedule for testing public support, and given that this schedule is prepared on a cash basis, we believe this schedule should also be prepared on a cash basis. Otherwise, there could be confusion on behalf of the reader.

Schedule C – Political Campaign and Lobbying Activities

Lobbying and political activities are two very different activities and by combining them together on one schedule there could be confusion on behalf of the reader as to the difference between the two concepts. Lobbying activity, within limits, is an acceptable activity for exempt organizations whereas political activity could jeopardize exempt status for Section 501(c) organizations. If this

form remains in its current state we suggest that: (1) lobbying activity should come first on the form so as not to confuse the preparer or reader; and (2) it should be made clear to the reader that lobbying activity is an acceptable activity for exempt organizations.

Schedule D – Supplemental Financial Statements

Part XIII. The heading description is erroneous. It should read "Reconciliation of Fund Balance." Furthermore, the math in this section appears to be in error because it forces the preparer to double count excess revenues over expenses. This is evident because Line 5 includes excess revenues over expenses along with Line 3, i.e., changes in unrestricted net assets includes excess revenues over expenses for the year.

Schedule F – Statement of Activities Outside the United States – Part I

For purposes of Schedule F, if an exempt organization provides grants to various entities whose work may include foreign activities in a charitable capacity, should these grants be reported on Schedule F? For example, what if an organization provides a grant to its sponsor who is a women's religious organization that is serving its mission by participating in charitable activity to help an underserved foreign population?

Schedule F – Statement of Activities Outside the United States – Parts II and III

The organization is required to disclose each organization and/or individual who received more than $5,000 in assistance or grants. While the question asks for organizations, can a municipality be identified as the recipient?

For non-cash assistance, can the organization include volunteer hours utilized in providing such services? If so, is there a standard hourly rate? Can the organization include the compensation paid to individuals (e.g. employees) who have provided assistance or otherwise organized or were involved in such assistance?

Schedule G – Supplemental Information Regarding Fundraising Activities

Part III, Line 10a. It needs to be clear to the preparer that this question relates only to awards, bonuses or gifts provided to employees as part of the "GAMING" activity as it appears this question is being posed within the gaming context. Please clarify.

Schedule K – Supplemental Information on Tax-exempt Bonds

Part I, General. In the case of organizations with multiple, large outstanding bond issues, the information requested in Part I will require an issuer to report an extraordinary amount of information. One single multi-million dollar bond issue may have several large dollar amount projects and many smaller dollar amount projects. As drafted, Part I requires the issuer to report all of these different projects and the date that each project was placed in service. For a multi-million dollar bond issue, this will require producing large amounts of documents which would not only be an onerous and burdensome task to complete for the issuer but would also be a time intensive review for the IRS. Why is this information necessary? As written, it suggests that compensating employees is wrongful.

Part II, Question 3. The question asks for the "Principal Amount Unspent (excluding reserves)." Both reporting tax-exempt entities and issuers need guidance on whether investment income is to be included or excluded from this amount.

Part II, Questions 9 and 10. These questions ask whether the bond was issued for the purpose of current or advance refunding a prior bond issue. Part I, Column (f) ask for a "Description of Purpose" for each issue. Questions 9 and 10 are repetitive because in answering Part I, Column (f), issuers will most likely state "Advanced Refunded Issue XXXX" as one purpose of the issue if a portion of that issue was used to advance refund a prior issue in accordance with the instructions for Column (f). These questions do not appear to elicit any additional relevant information beyond what will already be contained in Part I, Column (f).

Part III, General. It is unclear what the IRS is attempting to obtain from the questions in this section. In determining whether a bond issue meets the private business use test, the regulations calculate the private business use over a defined "measurement period." This measurement period could encompass several decades and clearly spans more than one reporting period. Any information submitted by issuers pursuant to this section will not assist the IRS in assessing whether the issuer meets the private business use test for any outstanding issue.

Part IV, General. This section requires an issuer to report whether third parties who received compensation in excess of $10,000 were selected through a formal process. However, the instructions do not define a "formal selection process." A liberal interpretation of formal selection process could include a simple meeting between the issuers' employees involved in the selection process to reach a recommendation for the responsible businessperson as to which third parties will be selected. A more conservative interpretation would require reporting only if there is a formal corporate selection policy with Requests for Proposal and responses obtained from independent sources. Clarification on the meaning of a "formal selection process" is needed.

DETROIT.2754410.5

From:	LaDonna McDaniel-Merville
To:	*TE/GE-EO-F990-Revision;
CC:	Paige Kisber;
Subject:	Comments on Proposed 990 -- Schedule H
Date:	Wednesday, September 12, 2007 4:38:18 PM
Attachments:	IRS990_letter.pdf

On behalf of the Hospital Alliance of Tennessee, I am submitting comments on the Proposed 990 – Schedule H. Thank you for your consideration of this information.

LaDonna McDaniel-Merville
Vice President
Hospital Alliance of Tennessee
211 7th Ave., North, Suite 400
Nashville, TN 37219
T: (615) 254-1941
F: (615) 254-1942
www.hospitalalliancetn.com

Hospital Alliance of Tennessee

An Association of
Not-for-Profit Community Hospitals

September 12, 2007

By Electronic Filing

Internal Revenue Service
Form 990 Redesign, SE:T:EO
111 Constitution Avenue, NW
Washington, DC 20224

RE: Comments on Proposed 990 – Schedule H

On behalf of the members of the Hospital Alliance of Tennessee (HAT), we appreciate the opportunity to submit comments on the proposed changes to the Form 990 and the new Schedule H for Hospitals. As community-owned or private entities that exist solely to serve the health care needs of their communities, not-for-profit hospitals have a long history of providing charity care and community benefit programs that, in many cases, far exceed the value of their tax-exemptions. These community benefit programs address unmet needs of special population and improve the health of the community.

Because not-for-profit hospitals have a long-term, pro-active commitment to community accountability and a social obligation to provide community benefit in the public interest, HAT is an advocate of reporting and annually conducts a voluntary community benefit reporting process of its membership. We encourage our members to attach a copy of the community benefit report to their organization's annual IRS Form 990.

As the IRS moves toward gathering more information about a hospital's community benefit activities, we feel it is important that the forms allow for a full and complete accounting to be captured. However, we feel the proposed Schedule H falls short of this goal. We ask that the following issues be considered:

- Delaying the implementation of Schedule H to allow hospitals time to reconfigure financial and data record keeping systems to collect the required information;
- Expanding the definition of community benefit to include a broader array of activities;
- Removing information unrelated to community benefit;
- Including Medicare underpayments and bad debt as community benefit.

211 Seventh Avenue North • Suite 400 • Nashville, Tennessee 37219
TEL: 615.254.1941 • FAX 615.254.1942 • www.hospitalalliancetn.com

Attached is a listing of specific comments about the proposed Schedule H for your consideration.

We appreciate the effort undertaken by the IRS to redesign the Form 990 and the new Schedule H for Hospitals, and we are grateful for your willingness to accept input from not-for-profit organizations regarding concerns about the proposed changes. As this process continues, we want to continue to be involved in any future design proposals.

Thank you for the opportunity to submit our comments and for your efforts to continue to improve draft Schedule H. If you have further questions, please contact me at 615-254-1941 or

Sincerely,

Paige L. Kisber, CEO & President

cc. Tom Gee, Chair

Attachment

Comments on Proposed Schedule H for Hospitals

MAINTAIN CONSISTENCY WITH THE COMMUNITY BENEFIT STANDARD

Revenue Ruling 69-545, the community benefit standard established by the IRS almost 40 years ago, is used by the IRS, the courts and the tax-exempt community in determining tax exemption for hospitals and health care organizations. It establishes the promotion of health in accordance with community needs in the absence of private benefit as the legal basis for hospitals' tax exemption. To be consistent with the basis on which tax exemption is granted to hospitals, the IRS should incorporate the community benefit standard into Schedule H, in the same manner it is incorporated into other forms and reflected in the IRS' own rulings and legal precedent. Further, the IRS should rely on it exclusively to determine compliance.

DELAY IMPLEMENTATION UNTIL 2010

To insure that hospitals have time to reconfigure financial and data recordkeeping systems needed to collect the information and for the IRS to develop the revised form and instructions, we urge a delay in implementation of the new Schedule H until 2010. This will allow for a more thorough and thoughtful approach to insuring the process meets both the oversight needs of the IRS while not unnecessarily burdening hospitals with additional work and costs.

INCLUDE MEDICARE UNDERPAYMENTS AND BAD DEBT AS COMMUNITY BENEFIT

Providing care for elderly and low-income patients who may not be able to afford the costs of their care is one way hospitals meet the needs of their communities. When Medicare does not pay the full cost of patient care, hospitals must absorb and compensate for these underpayments. In addition, Bad Debt is classified as uncollectible charges, excluding contractual adjustments, arising from the failure to pay by patients whose health care has not been classified as charity care. Due to the large number of uninsured patients that continue to seek care from hospitals, it is important to understand the financial impact of bad debt as a part of a not-for-profit hospital's contribution of care to those unable to pay for those services. We urge the IRS to incorporate the full value of the community benefit that hospitals provide by counting Medicare underpayments and bad debt as quantifiable community benefit and modifying the chart, instructions and worksheets accordingly.

ELIMINATE QUESTIONS UNRELATED TO COMMUNITY BENEFIT

We suggest eliminating the proposed chart on draft Schedule H, Part II relating to billing because the information sought in the chart has no relationship to the community benefit standard, does not contribute to the IRS' goal of promoting compliance, and is unnecessarily burdensome.

INCLUDE COMMUNITY BUILDING ACTIVITIES AS QUANTIFIABLE COMMUNITY BENEFIT

Not-for-profit hospital community benefit programs address unmet needs of special population and improve the health of the community. In many cases, not-for-profit hospitals have adopted responsibilities such as transitional housing for patients, maintaining and updating emergency preparedness, leadership in addressing environmental concerns, and many other less-traditional activities. These programs represent decisions by the not-for-profit hospital's board of trustees

who as representatives of the community determine what type of activities should be undertaken to contribute to the overall mental, physical and social well-being of the community. Therefore, we urge the IRS to reinstate reporting for community-building activities that contribute to prevention of illness or otherwise address concerns that ultimately affect the community's health and well-being.

Other Recommended Improvements to the Form

HAT also concurs with revisions to the form offered by the American Hospital Association, including:

1. Information on nonquantifiable benefits should precede other requests for information.
   The IRS should reconfigure the form to ensure that questions related to the community benefit standard and discretionary questions on nonquantifiable benefits precede the chart now labeled "Community Benefit Report."

2. The information provided by a hospital should be placed in context.
   IRS should, at the front of the form, add a new section with checkboxes allowing the filing organization to indicate the type of facility or facilities making the report.

3. The IRS should permit live links to hospital information or attachments.
   For a number of questions, including those pertaining to assessing community health needs, community benefit reports and charity care policies, where the amount of space provided is not sufficient to fully describe the hospital's activities, programs or policies, the IRS should permit (not require) the insertion of live links to such information on a hospital Web site, or allow attachments. The IRS already allows attachments to draft Form 990 and should do so here or permit live links.

4. The question on emergency room policies should be reformulated.
   The current question on emergency room policies and procedures should be included among those questions on the front of the form that pertain to the community benefit standard. It also should be streamlined to eliminate confusion and provide information consistent with the community benefit standard and with the experience gained by the IRS in asking similar questions as part of its Compliance Check Questionnaire project. We recommend the question be changed to read as follows:
   "Does the organization operate an emergency room? □ yes □ no.
   If yes, is it operated 24 hours a day? □ yes □ no.
   Other than being at capacity, did your emergency room deny services to anyone who needed services? □ yes □ no.
   If yes, explain."

5. The schedule should highlight a hospital's fundraising efforts for community benefit programs.
   To reflect the commendable efforts of many hospitals in raising additional funds for community benefit programs and activities, the IRS should add a question allowing the hospital to provide information about those activities, whether undertaken by the hospital itself or through related organizations. The worksheets also should properly reflect the value of this fundraising, giving hospitals full financial credit for these efforts as well.

6. Questions on management companies and joint ventures should be merged into other forms or eliminated.

Hospitals are required to provide information on joint ventures three times in three different forms: Form 990, Schedule H and Schedule R. This redundancy does nothing to enhance transparency or minimize burden. As a result, these questions should be eliminated from Schedule H. If these questions are significant to the IRS, then the entire tax-exempt sector should be required to respond to them. Questions on potential private inurement or benefit arising from ventures, for example, pertain to all exempt organizations, not just hospitals. It is unfair to hospitals, and ultimately to reviewers, to limit those questions to Schedule H.

7. Who must file should be clarified.

As drafted, all organizations that respond "yes" to the question "Did the organization operate, or maintain a facility to provide hospital or medical care?" must complete Schedule H. This question is too broad and will sweep up facilities that are not hospitals. A definition of "hospital" should be added as follows:

"A hospital is a health care organization that has a governing body, an organized medical staff and professional staff, and inpatient facilities and provides medical, nursing, and related services for ill and injured patients 24 hours per day, seven days per week. *A hospital is a facility (and all of its components) that is licensed in its state as a:*

√ *hospital*
√ *chronic disease hospital or hospital for treating certain disease categories*
√ *rehabilitation hospital*
√ *acute long term care hospital*
√ *children's hospital*
√ *psychiatric hospital*
√ *research hospital*

A hospital does not include:

√ *a nursing facility (including a skilled nursing facility, convalescent home, or home for the aged)*
√ *free standing outpatient clinic*
√ *community mental health or drug treatment/rehabilitation center*
√ *physicians' offices*
√ *facility for mentally retarded/developmentally disabled*
√ *facility for treating alcohol and drug abuse*
√ *hospital wing of a school, prison or convent*
√ *faculty practice plan*

8. The question on charity care policies should be reformulated.

The question now labeled 13b on charity care policies should be revised as follows: "[i]nclude in the description whether the organization (a) bases eligibility for free or discounted care on federal poverty guidelines, income or asset levels, (b) applies such policy to all of its facilities and allows its facilities to adapt its policy to particular community or individual needs, and (c) budgets annually for charity care." Hospitals are often faced with situations where patients in need don't neatly fit into a predetermined category, and hospitals need to deviate from their policies to provide assistance. The question should anticipate that hospital policies will need to be flexible enough to

accommodate those situations. We would also suggest that the IRS consider labeling this question "financial assistance policies."

9. As drafted, Schedule H must be completed in the aggregate for all facilities/hospitals under a single EIN. Part IV Facility Information asks for each "facility" to be listed.

Filers with multiple hospitals under a single EIN should have the option to complete Schedule H on either an aggregate basis or by completing it for each hospital included in the EIN.

10. For the section labeled "Quantifiable Community Benefits," in addition to moving it, change the chart heading from "Charity Care" to "Unreimbursed Costs for Care Provided," and change the column (b) header from "Persons Served" to "Patient Encounters." Omit the references to community benefit in the column (c) and (e) headers and restate as "Total expense" and "Net expense."

11. Instructions relating to community benefit operations should clarify that this category may include permissible physician recruitment expenses if part of an overall community benefit strategy in line with Revenue Ruling 97-12.

12. Improvements to Worksheets 5 (health professions education) and 7 (research) that will be submitted to the IRS by the Association of American Medical Colleges (AAMC) should be incorporated into worksheets for Schedule H.

13. Line 12a should be revised to ask whether the organization *or a related organization* prepares an annual community benefit report. This reflects the fact that, within a health system, an affiliated foundation of a hospital or the parent holding company may actually prepare a system-wide or hospital-specific community benefit report on behalf of the hospital.

14. The facility chart requires that the programs be described for each facility. This information could amount to multiple pages for many hospitals. The chart should be streamlined to ask only for the name and address of the facility in column A and for the "type" of facility in column B.

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From:	Lisa Gilden
To:	*TE/GE-EO-F990-Revision;
CC:	Schultz Ronald J;
Subject:	CHA Comments on Revised Form 990
Date:	Wednesday, September 12, 2007 4:15:49 PM
Attachments:	IRS 990 on ltrhd_FINAL.doc

Attached please find the comments of the Catholic Health Association of the United States on the Revised Form 900.

Thank you,
Lisa Gilden

Lisa J. Gilden, Esq.
Vice President, General Counsel
Catholic Health Association of the United States
1875 I Street, N.W., Suite 1000
Washington, D.C. 20006-5409
Main: (202) 296-3993
Direct: (202) 721-6319
Fax: (202) 296-3997
Email: lgilden@chausa.org

THE
CATHOLIC HEALTH
ASSOCIATION
OF THE UNITED STATES

September 12, 2007

Mr. Ron Schultz
Internal Revenue Service
Form 990 Redesign, SE:T:EO
1111 Constitution Avenue, NW
Washington, DC 20224

Dear Mr. Schultz:

The Catholic Health Association of the United States (CHA) is pleased to submit the following comments on the redesigned Form 990 for tax-exempt organizations. CHA is the national leadership organization representing the Catholic health care ministry in this country. Founded in 1915, CHA has over 1,950 members from all 50 states, forming the nation's largest group of nonprofit health care systems, hospitals, long-term care facilities and related organizations. CHA's member hospitals have been providing charity care and community benefit (collectively referred to as community benefit) and have been promoting the health of our communities for well over 100 years.

We welcome the opportunity to respond to the draft Form 990 and its various schedules. CHA is committed to many of the changes proposed in the new Form, not the least of which is added transparency and consistency in community benefit reporting. CHA is pleased that the IRS followed the CHA framework for reporting community benefit, which a growing number of hospitals and health systems have adopted on a voluntary basis. However, the request to provide additional information on the revised Form 990 needs to be balanced with the devotion of reasonable amounts of hospital staff time and resources in tracking and assembling such information. Our comments are offered in the spirit of creating the appropriate balance, so that tax-exempt hospitals can continue to focus on their essential purpose of caring for their communities.

WASHINGTON OFFICE
1875 Eye Street, NW
Suite 1000
Washington, DC 20006-5409
Phone 202-296-3993
Fax 202-296-3997
www.chausa.org

The comments offered herein were the result of a collaborative process between CHA and key personnel from many of our member hospitals and systems (such as community benefit directors, chief financial officers, and legal counsel). We also participated in numerous discussions about the revised Form 990 with other associations that represent nonprofit hospitals (including the American Hospital Association, the Association of American Medical Colleges, VHA, Inc., Premier, and the National Association of Children's Hospitals).

Our detailed comments include suggested improvements to the Core Form and to several of the Schedules. We comment first on the new Schedule H since it specifically applies to our hospital members. Key issues to be addressed include:

- clarifying the definition of which entities should file Schedule H;
- adding community benefit questions beyond those which are purely quantitative in nature;
- permitting aggregation of community benefit activities conducted by related hospital and non-hospital entities;
- including "community building" activities as a category of community benefit;
- eliminating Part II on billing and collections; and
- continuing to exclude Medicare losses and bad debt as community benefit categories.

In addition, we have included a revised definition of "independent member of a governing body" to ensure that religious women and men who have taken a vow of poverty will be considered "independent" even if they perform services for the reporting hospital.

Finally, CHA believes that in the interest of fairness, there should be a reasonable time period between the availability of final instructions for the new Form 990 and the implementation of the new Form. Organizations will need the information contained in the instructions to develop the necessary systems for collecting and compiling the data required to complete the new Form.

COMMENTS RELATED TO SCHEDULE H

1. Requirement to File Schedule H: Core Form, Part VII, Line 9; Glossary

Comments:

As currently drafted, Schedule H – Hospitals must be completed by any entity that "operates or maintains a facility to provide hospital or medical care." CHA recommends that only hospitals should be required to file a Schedule H. Accordingly, we believe that the question on Form 990, Part VII, Line 9 should be reworded as follows: "Does the organization directly operate a hospital? If yes, complete Schedule H."

In addition, the term "medical or hospital care" and its definition should be deleted from the Glossary. The glossary term "hospital facility" should be changed to "hospital" and the definition reworded as follows:

> A hospital is a health care organization that (1) has a governing body, (2) has an organized medical staff and professional staff, (3) has inpatient facilities, (4) provides medical, nursing, and related services for ill and injured patients twenty-four hours per day, seven days per week, and (5) the facility (and all of its components) is licensed or recognized in its state as a hospital. Some examples of hospitals are:
>
> - General hospital
> - Children's hospital
> - Rehabilitation hospital

- Psychiatric hospital
- Acute long-term care hospital
- Hospital for treating certain disease categories (e.g., cancer, heart, etc.)

Examples of health care facilities that are not hospitals are:

- A nursing facility (including a skilled nursing facility, convalescent home, or home for the aged)
- Institute for Mental Diseases (IMD)
- Free-standing outpatient clinic
- Ambulatory surgical center
- Ancillary service providers (i.e., laboratories, imaging centers)
- Community mental health or drug treatment center
- Physician group practices/faculty practice plans
- Physician offices
- Facility for mentally retarded/developmentally disabled
- Facility for treating alcohol and drug abuse
- Hospital wing of a school, prison, or convent
- Hospital foundations

Rationale:

The current threshold question of who should complete the Schedule H ("did the organization operate or maintain a facility to provide hospital or medical care") is too broad. The current Glossary definition of "medical or hospital care" would sweep in a number of organizations for which the questions on Schedule H are not applicable, or which would not have the necessary information or infrastructure to complete Schedule H. These include freestanding physician clinics and faculty practice plans; other outpatient clinics (such as free health clinics and federally qualified health centers); ambulatory surgery centers; ancillary service providers; skilled nursing facilities; staff-model HMOs; and hospital foundations. Asking these types of organizations to file a schedule labeled "Hospitals" is confusing and unduly burdensome.

CHA's proposal to narrow the definition of "hospital" and in turn, narrow the types of organizations who file Schedule H, is consistent with the standard definition of "hospital" used by The Joint Commission for accreditation purposes, and is sufficiently broad without being unnecessarily so. While CHA considered the definition of hospital currently used in the tax regulations (Treas. Regs. §1.170A-9(c)(1)(ii)), CHA believes that definition is too broad and would suffer from the same defect as the current definition in the Form 990 Glossary, namely, that it would sweep in facilities such as outpatient clinics, mental health and drug treatment centers, skilled nursing facilities, etc., for which the Schedule H questions are burdensome and inapplicable.

In addition, by focusing the definition on true "hospitals," the data collected by the IRS in response to Schedule H is more likely to allow "apples to apples" comparisons. The inclusion of a wide mix of health care facilities besides "hospitals" in Schedule H will likely lead to misleading data results. Moreover, the IRS has not clearly articulated

if and how the community benefit standard applies to other types of health care providers, especially since Rev. Rul. 69-545 is directed specifically at "hospitals."

CHA believes that Core Form 990, Part VII, Line 9 should be restated as: “Does the organization directly operate a hospital? If yes, complete Schedule H.” This would capture organizations that operate a hospital and also perform other exempt functions. For example, a non-government university that operates a teaching hospital (presumably something the IRS wants reported) would answer this revised question in the affirmative. If the question is left as “is the organization a hospital,” a university might not prepare Schedule H for its teaching hospital as it might deem itself a school rather than a hospital. Finally, adding the word "directly" makes clear that "parent" organizations of one or more hospitals would not themselves have to complete Schedule H.

2. Additional Community Benefit Questions

The current Part I of Schedule H is limited to presenting community benefit information of a quantitative nature. CHA strongly believes that community benefit is much more than simply "numbers." There are equally important qualitative aspects of community benefit that the current Schedule H does not capture. To that end, we are proposing two new Parts at the beginning of Schedule H that contain questions designed for hospitals to provide more complete information about themselves and the full scope of their community benefit activities. To make it easier to see what we are proposing, we have put these new questions in the format of the redesigned Form 990 on **Attachment A** to this letter**.** The information that these new questions request not only furthers the IRS goal of enhancing transparency, but also directly addresses the community benefit elements described in Rev. Rul. 69-545.

3. Aggregation of Community Benefit Activities

Comment:

CHA believes that there should be a mechanism whereby hospitals that provide community benefit through related organizations should be permitted to aggregate figures for purposes of reporting on the Community Benefit Report, currently Part I of Schedule H. CHA also believes that in certain circumstances an organization with multiple hospitals may want to report separately for each facility that provides community benefit. **Attachment B** sets forth a proposed question to be added to Schedule H to collect such aggregated information.

Rationale:

In addition to preparing a Schedule H for the reporting organization, CHA knows that many hospitals would like to have the option (but not the requirement) to prepare an additional schedule or schedules (specifically, Part I—Lines 1-11) for related organizations or hospitals within the reporting organization. This comes up in at least three situations: (1) a parent entity in a hospital system that does not directly operate a

hospital and otherwise would not be required to prepare schedule H, may like to aggregate all entities in its system and attach an aggregated schedule H to the parent entity's Form 990; (2) a hospital with related organizations that provide community benefit (i.e., a separately incorporated outpatient clinic that would not be required to prepare Schedule H) may wish to aggregate all related organizations and prepare an aggregated Schedule H; and (3) some organizations that have multiple hospitals within the same EIN may desire to prepare a separate Schedule H for each entity providing community benefit.

Situation 1

Many hospital systems are structured as multiple corporate entities governed by a parent holding company. The parent holding company would not be required to prepare a Schedule H because it does not directly operate a hospital. Nevertheless, the media, donors, state regulators and others may look to the parent's 990 and assume that the system provides no community benefit if no Schedule H is attached to the parent's 990. In this situation, many parent entities would like the option (but not the requirement) to prepare an aggregated Schedule H to attach to the parent's 990. This would be in addition to, and not in lieu of, the separate Schedule H that would have to be prepared by each corporation/EIN within the system. While the parent could refer an inquirer to the Schedule H of the 990 of each separate entity within the system, in some cases this could require the review of the 990s for 40 or more corporations. It would be burdensome for the inquirer to review that many returns, and it would be difficult for the inquirer to aggregate all the various Schedules to get an accurate or meaningful picture of what is happening at a system level.

Situation 2

Many hospitals have separately incorporated foundations and/or free-health clinics through which they provide a large portion of community benefit. Since those organizations are not hospitals under our proposed definition, they would not attach a Schedule H to their own Form 990s. If the hospital is not permitted to aggregate the community benefit provided by those related organizations, the information reported on Schedule H will understate the true community benefit provided by or on behalf of the hospital.

> Example: Consider two identical hospitals with two identical free-health clinics. Hospital A operates Clinic A within Hospital A's corporate entity. Because the combined facilities operate under one corporation and one EIN, the clinic's data will be aggregated for purposes of the Schedule H Community Benefit Report. By contrast, Hospital B operates Clinic B in a separate corporation under a separate EIN. If Hospital B is not allowed to include Clinic B on Hospital B's Schedule H Community Benefit Report, Hospital B's Schedule H will not adequately reflect the full scope of its community benefit activities, which are in fact identical to those of Hospital A.

This situation also would allow a hospital that is part of multi-hospital system to aggregate related organizations that are hospitals. For example, an urban hospital may

create a subsidiary to operate a suburban hospital. The revenues generated by the suburban hospital may be used to subsidize the charity care provided by the urban hospital. Most times, this support comes through inter-company transfers and bookkeeping entries so there is no check written by the suburban hospital to the urban hospital and no community benefit to report on the suburban hospital's Schedule H. To get a complete picture of the community benefit, each hospital may desire to prepare an aggregated Schedule H in addition to the separate Schedules that report just their respective separate operations.

Situation 3

The converse of Situation 1 is an organization that operates many hospitals within one EIN. Clearly, the instructions require the organization to prepare an aggregated Schedule H for all the hospitals operating under the same EIN. However, the organization may also desire to prepare a separate Schedule H for some or all of its separate hospitals. This is especially true for a system that operates in multiple states. If persons in one state want to know the community benefit provided by the hospital in that state, and if the only option is to review an aggregated Schedule H for 40 hospitals operating in 10 different states, this provides no useful or meaningful information for persons who only want to know about the community benefit provided by the hospital in their state. This thwarts, rather than enhances, the goal of transparency.

For these reasons, CHA believes that the purposes of complete and accurate disclosure and fairness are better served by allowing organizations to aggregate or separate based on the situations discussed above. This would always be optional (not required), and would always be in addition to the standard requirement that each reporting organization must prepare its own Schedule H. **Attachment B** sets forth a proposed question to be added to Schedule H to collect such information.

4. Revisions to Current Part I of Schedule H – "Community Benefit Report"

The following comments pertain to Schedule H, Part I, the Community Benefit Report table, comprising lines 1 through 11. We also have suggested revisions to the worksheets referenced in that table, which can be found attached as **Attachment C.** Among other changes, the worksheets now include definitions and guidelines that are designed to help hospitals with the process of completing the forms. The worksheets originally were supported by a chapter of text in the *CHA Guide to Planning and Reporting Community Benefit*, published in May 2006. The notes on the revised worksheets should prove helpful to hospitals that now will rely on them to complete Schedule H. The CHA Accounting and Reporting framework will be modified going forward to include these proposed revisions to the Worksheets.

Comments: Part I, column (b)

Part I, column (b) (persons served) should be deleted.

Rationale:

The information requested by the IRS in Part I, column (b) leads to confusion for hospitals required to complete Schedule H. The methodology used to count persons served is often inconsistent from hospital to hospital and is very difficult to track. Although CHA included "persons served" in the original CHA framework for reporting community benefit (in an effort to help individual hospitals track this measure through time), it was recognized that the measure would not be reliable if used to compare one hospital to another. Moreover, the term lacks uniform definition and has proved confusing, so few hospitals attempt to track this information.

For example, if a single charity patient visits the hospital five times in a year, is that one person served or five? Does it matter if the five visits are for the same diagnosis or different diagnoses? Some hospitals track "encounters" or "discharges" but even these are not universally defined from hospital to hospital. Further, neither "persons served" nor the more commonly tracked "encounters" or "discharges" make sense for some of the community benefit categories. For example, if the hospital is reporting community health improvement activities on line 5 (e.g., weekly radio programs or health education articles in newspapers that cater to underserved populations), how does the hospital determine persons served (number of radio listeners or number of newspaper subscribers)? If the hospital is reporting research activities on line 8, how does the hospital calculate persons served (all of humanity or the total number of persons suffering from the disease for which a cure is being researched)?

Comments: Part I, Column (d)

CHA recommends that the term, "Direct offsetting revenue," used in Part I, column (d) be defined as "funds and revenues received or accrued during the year that are directly restricted or assignable to the total community benefit expense of that activity."

Rationale:

Over the years, CHA members and other hospitals have raised questions about which revenues should be accounted for as an offset to the expenses of specific community benefit services and programs. The guidance that CHA consistently has provided follows two accounting principles: the "matching principle," which indicates that if the specific program generates revenue then that revenue should be counted as an offset to program costs. The second is that if donors or grantors restrict or designate the funds they provide to be used for a specific community benefit activity, the funds should be reported as used in that way. There are some categories of revenue where hospitals are guided to research the intent of their state legislature or Medicaid program; for example, Medicaid DSH funds can serve as an offset to charity care costs or to Medicaid losses – depending on the original purpose of the funding appropriated in their state.

Comments: Part I, Line 3

CHA recommends that the IRS add the following underlined words to Part I, Line 3: "net cost of other means-tested government programs."

Rationale:

In the CHA reporting framework, the item in Part 1, Line 3 of IRS Form 990, Schedule H was intended to include only "means-tested" (alternatively called "indigent") programs. Unless the IRS modifies Part 1, Line 3 to include this modifier, Medicare losses could be included by reporting organizations. CHA reporting guidelines exclude Medicare losses from community benefits. See Comment 9 below for CHA's rationale why Medicare losses should continue to be excluded from the community benefit report.

Comments: Part I, Line 4

CHA recommends that the term in Part I, Line 4, "Total Charity Care," be changed to "Benefits for Means-Tested Government and Charity Patients."

Rationale:

Classifying unreimbursed care from Medicaid and other means-tested government programs (Lines 2 and 3) as "Charity Care" creates confusion for organizations completing Schedule H.

Comments: Part I, Lines 9 and 10

CHA recommends that the IRS add a line titled, "Community Building Activities," in between lines 9 and 10 of Part I of Schedule H.

Rationale:

Community Building means activities carried out or supported to improve social factors found to be key determinants of health in communities: housing, education, environment, and economic prosperity. The inclusion of the community building category in the community benefit report is fundamental to a well-defined understanding of community benefit for the following reasons:

Community building activities support the health of persons in communities by preventing disease and injury, clearly an important aspect of "promotion of health," the basis for hospital tax exemption.

Rev. Rul. 69-545 recognizes that the "promotion of health" encompasses much more than the provision of medical treatment. Under the ruling, hospitals are called on to provide benefits that will make the community as a whole healthier. The ruling appropriately leaves it to the community board to determine what is needed in its community to best accomplish that goal.

The "community building" category, which includes activities that prevent disease and injury, is a fundamental component in promoting health. Programs specifically designed to help eliminate some of the root causes of illness and disease also can help eliminate the need for hands-on care later.

Testing and treating a poor child for lead poisoning is unarguably a community benefit. But supporting or actually participating in the removal of lead paint in schools and housing complexes should also be included as community benefit. This community building example not only would reduce the need for treatment but also would prevent the life-long and crippling effects of lead poisoning.

Health is widely believed to be determined, to a significant degree, by factors addressed through community building activities.

There is clear consensus in the public health community that social and environmental factors are strong determinants of health for vulnerable populations.

- The U. S. Department of Health and Human Services' Centers for Disease Control and Prevention publishes "Health Protection Goals" for the nation specifying safe and high-quality physical environments, healthy home environments, and schools that protect and promote health, safety and development of students.

- A recent study concluded that attention to social determinants of health, such as inadequate education, would save more lives than medical advancements. ("Giving Everyone the Health of the Educated: An Examination of Whether Social Change Would Save More Lives than Medical Advances," Woolf, et al. A*merica Journal of Public Health*, April 2007, Vol. 97, No. 4.)

- A scholar from the Institute of Medicine wrote last year that there is "an emerging notion of cumulative stresses from various sources – social class, income, employment, housing, home environment" affecting vulnerability to disease, and called for public health agencies and health care to work together to address these issues. ("Can Public Health and Medicine Partner in the Public Interest?" Michael McGinnis, *Health Affairs*, July/August 2006. Vol. 25, No.4)

Community benefit programs begin with an assessment of community need and setting priorities for action. Hospital community boards typically review assessment findings, identify priorities and approve community benefit plans and budgets. Therefore, if community building activities are undertaken, they are done so at the direction of the local, community-based board.

By not recognizing community building activities, the IRS would become the arbiter of which health care programs best serve a local community, a decision that is best made (and should be left to) local community hospital boards working in conjunction with local community groups. In a sense, this is a regulatory form of the judicially-created business judgment rule. Just as a court will not overturn a decision made by a board acting in good faith based upon reasonable due diligence, neither should the IRS or any other regulatory agency second guess a local, community-based board's decisions about which programs and services best promote the health of the local community.

Most community building services would otherwise be the responsibility of government; therefore providing community building services relieves a government burden.

Many community-oriented hospitals devote resources to economic development, low-income housing, job training, and other community building services. These are programs that frequently are provided by a local or state health department, another government agency, or another nonprofit organization. If the hospital did not provide the community building services, these activities would become the responsibility of government or another nonprofit organization.

Community building activities would justify exemption under 501(c)(3) on a stand-alone basis.

Every community building activity would qualify for exemption on a stand-alone basis if it were the only activity of the organization applying for exemption. The purpose of community benefit reporting under Schedule H is to have hospitals disclose the programs that justify their exempt status and that distinguish them from for-profit hospitals. When a hospital applies for exemption, they report community building activities and these form part of the basis of the exemption the IRS grants. Because they form part of the basis of the Service's decision to grant exemption, they are a legitimate use of the hospital's tax subsidy and they should be reported as community benefit.

To say that community building activities are not the basis of exemption is not only unsupportable by the law, it is akin to telling a university that they cannot take into account a hospital or museum the university operates in justifying the university's exempt status. Or, that a museum cannot take into account its educational programs in justifying its exemption. While the core purpose of a university may be education (rather than promoting health or the arts), and while the core purpose of the museum may be promoting the arts (rather than education), these ancillary programs still form the basis of their respective exemptions. Community building activities are similar. While they may not be part of the core purpose of the hospital (which is the provision of care), they still form the basis of the hospital's exemption because they promote health.

Community building activities help to distinguish not-for-profit tax exempt hospitals.

Community building initiatives come out of the charitable mission of not-for-profit hospitals. They do not provide opportunities for financial gain and they offer no market advantage. Therefore it is unlikely that a hospital operated to make a profit would engage in these programs and services. Nonprofit hospitals are under great pressure to distinguish themselves from for-profit hospitals. Community building activities are one way that nonprofits distinguish themselves from for-profits. If these programs, which promote the health of the community, are not undertaken by the nonprofits, they might not occur at all.

Not allowing the inclusion of community building activities would provide a disincentive to hospitals, to the detriment of community health.

While we do not believe that most hospitals would cease their current community building activities if they were not recognized as community benefit by the IRS, we also believe that not being able to report these services on the 990 would be a disincentive for investment in future community building initiatives. Such would negatively impact what we consider a positive movement of hospitals being part of community-wide efforts to improve conditions in troubled communities. Certainly the IRS would not want to create these unintended consequences by excluding community building activities. The exclusion of community building activities also would not necessarily mean that hospitals would be able to increase the amount of charity care they provide, particularly if the community building activities in question receive philanthropic support.

Community building activities are part of a comprehensive community benefit reporting system.

The category of community building has, for almost ten years, been a fundamental part of the CHA reporting process used by over 1,000 hospitals, which the IRS has chosen to use for reporting community benefit. If one of eight categories in the reporting framework is excluded, the overall reporting system is disrupted. Organizations carrying out these programs will have to develop duplicative reporting systems, and hospital-published community benefit reports will not be in line with submitted IRS Forms 990.

Comments: Part I, Line 12(a) and (b)

CHA believes that these questions should be moved to the new Section on non-financial community benefits discussed under Comment 2 above. They appear in a revised format on lines 1 and 2 of **Attachment A.**

Comments: Part I, Line 13(a) and (b)

CHA believes that these questions should be moved to the new Part II on non-financial community benefits discussed under Comment 2 above. They appear in a revised format, on lines 3 and 4 of **Attachment A.**

The question about whether the charity care policy is uniformly applied to all facilities has been revised to ask whether each facility is able to adapt the policy to meet the particular needs of its community. The question about whether charity care budget caps result in some patients who otherwise qualify for charity care being denied charity care has been revised to ask whether the organization annually budgets for charity care.

Rationale:

With respect to the uniform application question, facilities need the ability to adapt policies to meet local demographic and other needs, and in many cases state laws. Within a given system (which may operate in more than one state), the following types of hospitals may adapt their charity care policies to meet the differing needs of their communities: suburban versus rural versus urban hospitals, teaching and research hospitals, and children's hospitals. The question about budget caps implies that nonprofit hospitals are required to apply charity care policies without regard to cost and impact on the financial well being of the hospital.

Even when the IRS required hospitals to provide charity care, they were not required to provide unlimited amounts of charity. See Rev. Rul 56-185. Certainly, Rev. Rul. 69-545 does not require that a hospital provide non-emergency care up to its last available dollar, recognizing that hospitals need reserves to purchase new equipment, provide new needed services, etc. There is no doubt that this country is experiencing a health care crisis in that there are 47 million persons without insurance. Charity care provided by nonprofit hospitals does much to help alleviate the problem, but it is not something they can or should be required to do all on their own. The way this question is currently worded implies that such hospitals wantonly turn persons away due to unreasonable restrictions on the funds available for this purpose, which is not the case.

5. Part II – Billings and Collections

Comments:

CHA recommends that Part II of Schedule H be deleted.

Rationale:

CHA believes that Part II requests information that neither can be tracked and disclosed by the hospitals, nor would be useful even if it could be tracked. For example, discounts provided to insurers are frequently confidential and proprietary and cannot be disclosed under agreements with insurance companies. Even if an aggregate discount among several insurers is disclosed, if a single payor in a community is predominant (which is the case in many communities), the dominant payor's discount can be imputed. Further, "uninsured" is not a category that hospitals track. Some track "self-pay" patients, and while that includes uninsured patients, the category is much larger than the merely uninsured. "Self-pay" can include patients whose bill is being paid by worker's compensation insurance, who have been injured in a car accident and whose bill is being paid by indemnity insurance, or who are paying through a cafeteria plan or health savings account.

Finally, neither the IRS nor Congress has ever stated that a hospital's billing and collection and discount practices are a basis for tax-exemption.

6. Part III—Management Companies and Joint Ventures

Comments:

As proposed in the current Core Form and Schedules H and R, a hospital has three different places where it must report joint venture activities: Core Form, Part VII, Line 8; Schedule H, Part III; and Schedule R. CHA believes that all the joint venture questions should be in one place on the form. Specifically, the questions on the Core Form (Part VII, Line 8) and Schedule H (Part III) should be consolidated into Schedule R so that all nonprofits (not just hospitals) are answering the same questions.

Many nonprofits, not just hospitals, participate in joint ventures (schools, non-hospital health care facilities, trade associations, museums, and low-income housing organizations to name a few). CHA does not believe that hospitals should be singled out. Moreover, to the extent that other nonprofits participate in joint ventures, CHA believes that in the interests of transparency and disclosure such nonprofits should also disclose their joint venture activities.

The IRS should be aware that in some circumstances hospitals may not be able to disclose the ownership interest of other parties due to confidentiality provisions in the agreements with those parties. Moreover, to the extent a hospital is a minority owner, it may not know the ownership interest of other parties. For these reasons, the hospital should be required to disclose only its own interests.

To the extent that the hospital owns an interest in a publicly-traded partnership (for example, as part of its investment portfolio) it should not be required to disclose such interests. They would already be disclosed in the financial information requested in other parts of the From 990.

Finally, the IRS may want to consider some thresholds before a nonprofit is required to disclose joint ventures: a minimum percentage of ownership by the nonprofit, a minimum value of the interest held by the nonprofit, a minimum amount of revenue generated by the joint venture, some ratio of the joint venture's revenue to the hospital's revenue, some ratio of the value of the hospital's interest in the joint venture to the value of all the hospital's assets, or some combination of the above (i.e., any joint venture in which the hospital owns at least an *x*% interest and in which the pro rata share of income from the joint venture accounts for at least *y*% of the hospital's total revenue). Otherwise the list from some corporations that operate many different hospitals could be so long as to be difficult to analyze meaningfully. CHA would welcome the opportunity to discuss with the IRS various thresholds, and which approach might be most appropriate to adopt.

7. Part IV—General Information

Comments:

CHA believes that this section should be deleted. These questions have been included in our proposed **Attachment A** (see Lines 1, 4, 5, and 14). We believe the question about emergency room policies and procedures is too broad, and have not included it on our **Attachment A**. The policies could easily number in the hundreds

(employment policies, treatment protocols, reporting requirements, staffing requirements, purchasing requirements, etc.), most of which are not germane to the types of information Schedule H is seeking nor unique to the emergency room operations. We believe the core inquiry is whether the emergency room denies services to anyone in need (other than when the emergency room is at capacity or as otherwise permitted by law), and we have specifically asked that question.

8. Part V—Facility Information

Comments:

CHA believes that listing the "type of service provided" at each facility in column (A) and the "activities and programs conducted at each facility" in column (B) is repetitive. CHA has attached a revised Part V (now described as Part IV) as **Attachment D** to illustrate how we propose to eliminate this redundancy.

9. Medicare Losses and Bad Debt

CHA understands that other organizations are taking the position that Medicare losses and bad debt should be counted as community benefit. CHA believes that these should not be included in the Community Benefit Report.

The reasons for excluding Medicare losses are as follows:

- If there are programs for seniors that respond to identified community needs, generate losses and/or meet other criteria for inclusion as community benefit, they can be included as "subsidized health services" in the reporting framework
- Serving Medicare patients is not a differentiating feature of tax-exempt hospitals; many for-profit hospitals compete aggressively for these patients
- The federal government and MedPAC are unlikely to consider Medicare losses as community benefit because Medicare rates are analyzed and adjusted on a regular basis. Including Medicare shortfalls would place different federal agencies at odds regarding the adequacy of Medicare payment
- Access problems for Medicare patients have not yet been observed by MedPAC (*If, at some point, access problems emerge for Medicare patients, the rationale for including Medicare services as community benefit increases)*
- Counting Medicare losses as community benefit is met with skepticism by policy makers and others, and significantly decreases the credibility of tax-exempt hospital community benefit reports

The reasons for excluding bad debt are as follows:

- IRS Form 1023 indicates that to qualify for federal tax exemption, hospitals must "distinguish between charity care and bad debts"
- If there are many patients who are truly unable to pay and whose accounts are being written off to bad debt, then perhaps charity care policies and/or billing practices should be adjusted (*In fact, over the past few years, many Catholic hospitals have changed their policies and improved their ability to identify patients eligible for financial assistance)*
- Excluding bad debt will encourage better differentiation between those who can pay but do not and those who are truly poor
- If community benefit includes all "uncompensated care," then hospitals with more generous charity care policies will not be differentiated from those with less generous policies
- HFMA Principles & Practices Board Statement 15 allows patient accounts to be assigned to charity on the basis of incomplete information. There is no longer a need to require "perfect" documentation
- Technology solutions are emerging that help hospitals qualify patients for financial assistance, even if there is incomplete information
- Some consider bad debt a "cost of doing business" that affects taxable and tax-exempt organizations
- Adding in bad debt would jeopardize the credibility of tax-exempt hospital community benefit reports

CHA believes that the IRS should endorse HFMA Statement #15 regarding the calculation of bad debt and the timing of the determination.

COMMENTS RELATED TO GLOSSARY OF DEFINED TERMS

10. "Independent Member of Governing Body"

Comments:

We believe that the definition of "independent member of the governing body" in the Glossary should be revised. Religious women and men who have taken a vow of poverty should be considered to be "independent" even if they perform services for a sponsored organization. In fact, the Service already has taken this approach when adopting the intermediate sanctions regulations. See Reg. 53.4958-3(e)(3)(i), which excludes from the definition of a disqualified person those who have taken a bona fide vow of poverty. The same approach should be followed in the definition of "independent member of governing body" used in the Glossary for the Draft Form 990 Redesign

Our proposed language is as follows (with the **bold** language being the proposed addition to the existing language):

An "Independent Member of a Governing Body" is a person:

- Who is not compensated as an employee of the organization;

- Who does not receive compensation or other payments from the organization as an *independent contractor* (other than reimbursement of expenses or reasonable compensation for services provided in the capacity of serving as a member of the *governing body*);
- Who does not receive, directly or indirectly, material financial benefits from the organization except, if applicable, as a member of the charitable class served by the organization; and
- Who is not a spouse, sibling, parent, or child of any individual who is employed by, or receives compensation or other material benefits from, the organization; **or**
- **Who has taken a bona fide vow of poverty and provides services to the organization as an agent of a religious order.**

Rationale:

CHA generally supports governance by boards that include individuals who are not executives or employees of the organization. However, Catholic hospitals have a long tradition of religious sponsors (usually Sisters) who not only serve on the governing boards of their sponsored hospitals and health care systems but also provide services at such hospitals/systems. As members of religious orders who have taken a vow of poverty, the Sisters are not personally compensated or taxed on the amounts earned from their service, but instead are acting as agents of their religious order, which is exempt under Section 501(c)(3). Payments for their services are made to their order under rules set forth by the Service in Rev. Rul. 77-290.[1]

11. <u>"Supported Organization," "Supporting Organization," and "Type I, Type II and Type III Supporting Organizations"</u>

Comments:

We believe a more appropriate definition of "supported organization" would be: "An organization described in Section 509(a)(1) or 509(a)(2) which is supported by an organization described in Section 509(a)(3)." The current definition of "supported organization" only makes reference to Section 509(a)(3) and the term is not defined in Section 509(a)(3).

Similarly, we believe that the definition of "supporting organization" should be as follows: "A public charity that meets the definition set forth in Section 509(a)(3) of the Code." The current definition just makes reference to Type I, II and III organizations and those organizations are not defined.

[1] Rev. Rul. 77-290 provides that a religious providing services will be considered an agent of his or her order and will not be liable individually for federal income or employment taxes on compensation paid by the employer, provided three criteria are met: (1) the religious must be subject to a vow of poverty; (2) the religious must be providing services for an employer listed in the Official Catholic Directory (i.e., included in the Catholic Church Group Ruling) at the direction of his or her ecclesiastical superiors; and (3) the religious must remit the compensation to his or her religious order, which must be exempt from federal income tax under section 501(c)(3) of the Code.

Finally, the form and various definitions make reference to Type I, II and III supporting organizations, but these terms are not defined. We think the Glossary should include the following definition: "Type I, II and III Supporting Organizations: A Type I or II supporting organization has the meaning set forth in Section 4942(g)(4)(B) of the Code. A Type III supporting organization has the meanings set forth in Section 4943(f)(5)(A) of the Code. Whether or not a Type III supporting organization is functionally integrated is described in Section 4943(f)(5)(B) of the Code."

12. "Unrelated Business Income," "Unrelated Business Gross Income," and "Unrelated Trade or Business"

Comments:

The definitions of "unrelated business income" and "unrelated business gross income" make reference to Code Section 513 when defining "unrelated trade or business." However, the definition for "unrelated trade or business" has no such reference and further includes a definition which may not be complete. For clarity and consistency, we would propose the following definition of an unrelated trade or business: "Any trade or business described in Code Section 513. See also Publication 598 and the Form 990-T instructions for a discussion of what is an unrelated trade or business."

COMMENTS RELATED TO THE CORE FORM 990

13. Part I

Comments:

Line 1 should allow the hospital to provide a link to appropriate pages of its website. In the "Activities and Governance" section, a line should be added for hospitals to report the total amount of community benefit from Schedule H (Part I, Line 11, column (e) of Schedule H).

Rationale:

In Line 1, the question asks the hospital to "Briefly describe the organization's mission." Similar to what we have suggested in various places on our **Attachment A**, we believe that reporting hospitals should be able to supplement this answer with a link to their website. Because Part I will be the primary page that people look at, it would be beneficial to be able to provide that link on this first page of the Form 990. Similarly, because the goal is to provide a one-page snapshot of the organization, there should be a line in Part I where hospitals report the total amount of community benefit reported on Schedule H.

14. Part II, Section A

Comments:

Part II, Section A requests that certain compensation information be provided for "officers, directors, trustees and key employees." This is the same category of persons for whom information was requested in prior versions of the Form 990. We believe definitions need to be clarified. "Directors and trustees" should be defined as "voting members of the governing body who are entitled to vote on any matter over which the governing body has authority, and persons or institutions who serve as trustees under state law."

Rationale:

This is the definition used for intermediate sanctions purposes under Treas. Regs. §53.4958-3(c)(1). Non-voting members could include honorary members, advisory members, lifetime members, members emeritus, etc. For some organizations, such persons can number in the hundreds, and reporting all of them (presumably all of whom serve without compensation) would be burdensome. Further, as non-voting members, they do not exercise substantial influence over the organization, so including them would not provide any useful information.

Comments:

We believe the hospital should report compensation information only for "employees that meet the definition of a disqualified person under §4958 and the regulations thereunder." The requirement to report information for "officers" and "key employees" should be eliminated.

Rationale:

We believe the definition of "officer" and "key employee" is not clear. In the past, the uncertainty over which persons are included in such categories has led to confusion and inconsistency in reporting. Some hospitals report only C-suite executives and senior and executive vice-presidents, while others report anyone with the title vice-president or department director (which in many organizations, especially multi-hospital systems, could be numerous persons). The two definitions provided in the glossary overlap (e.g., the definition of "key employee" includes anyone with duties similar to an "officer") and both definitions include components of the intermediate sanctions definition of a disqualified person. Limiting reporting to employees who are disqualified persons under intermediate sanctions would create somewhat of a bright line test because hospitals would know they could exclude anyone making less than the highly compensated employee threshold under §414(q)(1)(B)(i) as permitted by the regulations under §53.4958-3(d)(3). The threshold for 2007 is $100,000, so hospitals would know that they would not have to report anyone making less than that amount.

Comments:

With respect to Column (E) ("Reportable Compensation From Related Organizations"), we believe the instructions should contain the following exception: "if a person receives no compensation from the reporting organization, and if the only

reportable compensation comes from a related organization that is not required to file a 990 (e.g., a church), that person's compensation from the related organization does not have to be reported on the organization's 990."

Rationale:

To give an example, a bishop of a diocese may serve on a hospital board. The bishop receives no compensation from the hospital. Because the diocese may be a related organization, however, the bishop's salary from the diocese would have to be reported on the hospital's 990, even though the diocese would not itself have to file a 990 and report the bishop's salary. This rule would affect most religious organizations that sponsor or are affiliated with hospitals. It could lead to reporting of information regarding religious persons that otherwise is not required to be reported.

15. Part II, Section B, Line 8

Comments:

Line 8 requires that Schedule J be completed for any person receiving more than $250,000 "of reportable or other compensation, including deferred compensation, non-taxable fringe benefits and expense reimbursements." We believe that both here, in establishing the $250,000 threshold, and on Schedule J, only taxable expense reimbursements should be included.

Rationale:

Non-taxable expense reimbursements for a particular executive could be quite large. As long as they are pursuant to an accountable plan (as defined by the Code and Regulations) and therefore pursuant to a legitimate business purpose, reporting such legitimate business expenditures as compensation provides distorted and misleading information. For example, if the CEO provides an appreciation lunch for the nursing staff and puts the charge on her credit card and is subsequently reimbursed, reporting this expense somehow implies that the CEO personally benefited when in fact it was a legitimate business expense. If all similar charges are aggregated over the course of a year and reported on the 990, such reimbursement could be quite large and give the false impression that the CEO received a windfall. Moreover, if forced to report non-taxable expense reimbursement, reporting could come down to whether an executive uses a company credit card (and thus receives no reimbursement and has nothing to report) or uses a personal credit card (and has non-taxable expense reimbursement to report)—an inconsistency that would not provide an apples-to-apples comparison.

16. Part III, Line 3b

Comments:

Line 3b asks how many transactions were reviewed under the conflicts policy. We believe this question should be deleted as the answer could be misconstrued.

Rationale:

If the answer is that 50 transactions were reviewed, does this mean that the organization is hyper-diligent and reviews every single transaction that even remotely raises a conflict issue (to be commended), or that the board is awash in conflicts and donors and regulators should be duly apprised? If the answer is zero, does this mean the board is asleep at the switch and has let numerous conflict transactions slip by without review, or that the board is so well educated and conscientious that they never enter into conflict transactions so none is ever reviewed? Without the opportunity to explain the context of the answer, we believe that reporting only the number of transactions reviewed provides no useful information and, worse, provides information that could be misconstrued.

17. Part III, Line 9

Comments:

Line 9 asks whether the organization has an audit committee. We believe this question should be revised as follows: "Does the organization have an audit committee (or other committee such as finance, investment, executive or the entire board acting as a committee of the whole) that oversees the audit function?"

Rationale:

With smaller hospitals especially, many functions (finance, investment and audit) are combined into one committee, sometimes the executive committee. The name of the committee is not important, but what people reading the 990 presumably want to know is whether the board, or a committee thereof, rather than employed officers, oversees the audit function and the work of the auditor.

18. Part III, Line 10

Comments:

Line 10 asks whether the governing body reviewed the form 990 before it was filed. We believe the question should be deleted as it is inconsistent with what is asked of other corporate taxpayers. In the alternative, if the IRS does decide to keep a question on this topic, then it should be changed to: "Does the governing body (or committee thereof) review the 990 (or a summary thereof) and is it familiar with its contents?"

Rationale:

We are not aware of any requirement in the Code for Board review of a tax form prior to filing. For example, there does not appear to be a requirement that the Board of a C-Corporation review Form 1120 before filing. Why should tax-exempt organizations be singled out in this regard? The filing is already subject to a penalty of perjury, which should be sufficient.

In any event, it is impracticable for the entire governing body to review the form before it is filed. Many boards only meet quarterly, and the Form 990 is often completed only days before the filing deadline. While CHA believes that it is good practice for board members to be aware of the contents of the Form 990, it believes that review by a committee of a comprehensive summary of the 990 should be sufficient. Thus the question, if deemed necessary, should be revised to ask only about board or committee review of the Form 990 (or summary thereof) in general, not prior review.

19. Part III, Line 11

Comments:

Line 11 asks whether certain information is publicly disclosed. If the box for disclosure on the website is checked, the organization should also be asked to provide the web address or URL. In addition, for hospitals, the following categories should be added: information on charity care, billing and collection, and community benefit programs.

20. Part VIII, Line 2; Glossary; Schedule C, Part II-B, Line 1; Instructions to Schedule C; Schedule F, Part I, Line 3

Comments:

Part VII, Line 2 of the Core Form 990 asks if the organization has engaged in "lobbying activities." The glossary defines "lobbying" as "all activities intended to influence foreign, national, state or local legislation." We believe the word "foreign" should be deleted.

Similarly, the word "foreign" should be deleted from the definition of "lobbying activities" on page 4 of the instructions to Schedule C.

Similarly, the word "foreign" should be removed from Schedule C, Part II-B, Line 1

Similarly, Line 3 should be deleted from Part I of Schedule F.

Rationale:

The Code and Treasury Regulations do not include foreign legislation in the definition of lobbying, and the Form 990 instructions should not extend beyond the reach of the treasury regulations. See Treas. Regs. §1.501(c)(3)-1(c)(3)(ii); Code Section 4911(e)(2); Treas. Regs. 56.4911-2(d)(1)(i).

COMMENTS ON SCHEDULE C

21. Part II-B, Line 1

Comments:

The word "foreign" should be deleted.

Rationale:

See Comment 20 above.

COMMENTS ON SCHEDULE F

22. Captive Insurance Companies

Comments:

Hospitals that have captive or subsidiary insurance companies that are incorporated in a foreign country should not be required to prepare Schedule F merely because of this foreign domicile and absent any activities or programs of a charitable nature in a foreign jurisdiction or country.

Rationale:

Many hospitals have subsidiary or captive insurance companies that are incorporated in foreign jurisdictions. We believe that the intent of Schedule F is to report charitable activities, operations and grants in foreign countries. It should not apply to an entity domiciled in a foreign country that conducts its activities in the United States. We therefore believe that a hospital's subsidiary insurance company should not be reported on Schedule F.

23. Part I, Line 3

Comments:

Line 3 should be deleted.

Rationale:

See Comment 20.

COMMENTS ON SCHEDULE J

24. Line 1 in General

We believe the title of Line 1 should be amended as follows (with the underlined portion being added): "Current and Former Officers, Directors, Trustees, Key Employees, and Highly Compensated Employees." Further, we believe that the second

sentence of Line 1 should refer to “Part II” rather than “Part III,” as follows: “Do not list individuals that are not listed on Form 990, Part II.”

25. Line 1, Column D

Comments:

The instructions should clarify that de minimis fringe benefits under Code Section 132(e) should not be reported on Column D.

Rationale:

Code Section 132(e) states that the reason that a de minimis fringe benefit is not taxable is because it is “so small as to make accounting for it unreasonable or administratively impracticable.” If Congress has decided that hospitals (and other employers) should not have to bear the burden of tracking those benefits for taxation purposes, the IRS should not impose the burden through the 990. Therefore, Section 132(e) de minimis fringe benefits should not have to be tracked or reported on Column D.

26. Line 1, Column E

*Comments***:**

CHA recommends that the IRS only require filing organizations to report taxable expense reimbursements, as opposed to both taxable expense reimbursements and non-taxable expense reimbursements.

Rationale:

See Rationale subsection in section 15 above.

27. Line 3

Comments:

CHA recommends that question 3 regarding reimbursement of first-class travel, club dues, or use of personal residence be modified. It should not be simply a yes or no question. Instead, the Form should ask for an explanation if a "yes" answer is provided. Further, the instructions should provide a definition for "club" and what constitutes the "use" of a "personal residence."

Rationale:

Question 3 is too vague and the reader may misinterpret an organization's answers. A space should be provided, or a request made for an attachment, to provide an explanation of a "yes" answer to avoid misleading the reader. For example, an organization might allow first class travel only for international flights. Further, the word "club" could mean country club, health club, airline club, etc. The "use of personal residences" should also be defined. For example, is there some minimal time that the use must be provided before this is applicable?

28. Lines 4 and 5

Comments

CHA recommends that the IRS provide some explanation and examples of when compensation is "determined in whole or in part on revenues" or "net revenues," respectively. Moreover, the term "net earnings" should be defined and there should be space to allow the filing organization to have an opportunity to explain its answers to lines 2-5.

Rationale:

There are many bonus arrangements that may use "revenues" or "net revenues" as a factor in determining a bonus amount. For example, the revenues of a department of a business may be a factor in the bonus of a department chair.

COMMENTS ON SCHEDULE K

29. General Comments

Much of the information requested in Schedule K is already reported on Form 8038. If the goal of Schedule K is to provide information to the IRS for compliance purposes, then this information is already available to the IRS on Form 8038. If the goal is to increase transparency and disclosure, then the IRS can instruct that the Form 8038 be attached to the Form 990 so that it is also available for public inspection. Requiring organizations to fill out both Schedule K and Form 8038 is duplicative and burdensome for reporting organizations (some of CHA's larger systems have estimated that the cost of compliance to prepare Schedule K alone could exceed $1 million per year). For this reason, we suggest the Schedule be deleted. To the extent that some version of Schedule K remains, CHA believes that it should only apply to bond issues after the effective date. Retrospective application would require organizations to go back in time and find information that they were never required to track in the first place. For some bond issues that occurred 20 or more years ago, this would be nearly impossible.

30. Obligated Group Borrowing

Many organizations, especially hospitals, are part of a group of organizations that borrow as an obligated group. Borrowing does not occur at the individual hospital level. In these situations, the IRS needs to clarify which entity should fill out Schedule K. If there is a parent holding company for the obligated group, then it makes sense for the parent entity to fill out Schedule K. Each hospital in the obligated group should not have to fill out an identical Schedule K. If there is no parent holding company, which sometimes is the case, the members of the obligated group should be able to decide which entity prepares the Schedule K, but not all entities should be required to prepare an identical Schedule K. The nature of obligated group borrowing is another reason that CHA believes that Schedule K should be deleted in favor of attaching the Form 8038. Form 8038 takes into account obligated group borrowing because it is prepared by the issuer of the bonds.

31. Legally Defeased Bonds

CHA believes the IRS needs to clarify how legally defeased bonds should be reported, both in the Core Form and on Schedule K. For example, legally defeased bonds would not generally appear on the balance sheet of the organization and therefore would not appear on the Core Form at Part VI, Line 21 (and accordingly, a Schedule K would not be required). However, they still could be considered "outstanding" and therefore the answer to Part VII, Line 6.a. of the Core Form would arguably be "yes" (and a Schedule K would be required). To avoid this possible inconsistency, CHA believes that the instructions should clarify that legally defeased bonds should not be reported on the Core Form, Part VI, Line 21; on the Core Form, Part VII, Line 6.a.; or on Schedule K.

32. Temporary Period Exceptions

Both Schedule K, Part II, Line 11 and Core Form, Part VII, Line 6.b. address temporary period exceptions. Schedule K asks whether the financing qualified under a temporary period exception. The Core Form asks whether any net bond proceeds were invested beyond a temporary period exception. CHA believes a "yes" answer on the Core Form could be misleading because the Code and Treasury Regulations permit unspent proceeds to be invested beyond a temporary period exception (e.g., if investment yield restrictions are complied with or yield reduction payments are made). Accordingly, CHA believes the question should be deleted. If the question is not deleted, it should be amended to read: "Did the organization invest any net proceeds of tax-exempt bonds beyond a temporary exception period not in compliance with the Code and Regulations."

33. Current and Advance Refundings

Both Schedule K and the Core Form ask about current and advance refundings. CHA believes that the Core Form, Part VII, Line 6.c., should be amended to ask: "Did the organization maintain an escrow account other than an advance refunding escrow account or a current refunding account at any time during the year to defease tax-exempt bonds?" CHA is not clear why the question, as currently drafted, should apply to advance refunding escrows but not to current refunding escrows.

34. Part I, Column (g): Date Placed In Service

As indicated above, many hospitals finance as part of an obligated group of borrowers. Any one bond issue could be for thousands of assets across multiple hospitals. If a placed-in-service date is expected for each expenditure, hospitals would have difficulty obtaining the information. Particularly for older issuances, this could be extremely onerous and time-consuming to obtain. The IRS also needs to clarify whether they are seeking the date when final proceeds were expended, or the actual date each financed project/asset was placed in service. Reporting the final expenditures would be easier than reporting the date projects/assets were placed in service.

If the IRS wants organizations to report the dates projects/assets were placed in service (rather than final expenditure dates), the IRS should consider some threshold levels or categories. Because so many assets are financed with obligated group borrowing, it should be permissible to report by category and time period rather than a date specific for each particular asset (which could number in the thousands). For example, it likely is not necessary to say when a particular x-ray machine was placed in service but should be sufficient to say that "multiple equipment was placed into service between 2005 and 2007." For assets exceeding a certain threshold, such as a new hospital, a specific date that the project/asset was placed in service might be acceptable.

35. Part II, Lines 1-11

This part should be deleted. Much of the information requested in Part II can be found in the Form 8038. For information not in the 8038, finding the information for older bond issuances could be extremely burdensome, if not impossible. Sometimes this information simply does not exist for older issues (e.g., whether a 1981 financing qualified under a temporary period exception). To the extent any of these questions remain in the final schedule, they should only apply to bond issues after the effective date of the new Form 990 and should not apply retroactively.

36. Part III, Lines 2b and 3b

These questions should be deleted. These questions ask whether management and research agreements meet the safe harbors set forth in Rev. Procs. 97-13 and 97-14, respectively. These questions will be quite burdensome to address. The safe harbors are facts and circumstances tests, and it is not always immediately clear whether a contract meets the safe harbor. In order to answer that a contract meets the safe harbor, is good faith belief sufficient or is an opinion of counsel needed? Further, meeting the safe harbor is not required because falling outside the safe harbor does not necessarily mean the contract results in private use. Accordingly, few hospitals track which contracts meet the safe harbors and which do not. A given hospital system may easily have 5,000 contracts or more, and reviewing each one to determine whether it satisfies the safe harbor would be unduly burdensome and expensive.

37. Part III, Line 4

The question asks for the percentage of project that was subject to a management or research agreement. First, hospitals generally do not track this information and doing so would require a significant expenditure of time and resources. Second, it is not entirely clear what is being asked for. To the extent that the organization determines that

a contract meets a safe harbor, or otherwise does not constitute private use, or constitutes private use that in the aggregate does not exceed the statutory cap, why should it even have to track the information requested? To report contracts that meet the safe harbors is misleading (implying that they constitute private use when they do not). Also, it is not helpful information to determine compliance with the private use rules because the hospital would be reporting (in one figure) both contracts that do not constitute private use and those that might constitute private use. This would seemingly lead to the conclusion that the question should be asked with respect to only contracts that do not meet the safe harbor. However, since it is not always clear which contracts meet the safe harbor, this is not a workable solution either. Accordingly, CHA believes this question should be deleted.

These are just a few of the facts and questions that demonstrate that a great deal of clarification is needed for many of the questions on Schedule K and, moreover, why Schedule K should be abandoned in lieu of having hospitals attach their forms 8038.

Comments on Schedule R

38. Comments

CHA believes the proposed Schedule R should be deleted and replaced with Part XI of the current Form 990 (2006). The current Form 990 asks for any transfers between the reporting organization and any controlled entities under the definition of Code Section 512(b)(13). This information is requested to ensure compliance with the unrelated business income rules and the Pension Protection Act of 2006. The proposed Schedule R greatly expands the information required to be reported as well as the entities that have to report, and would substantially increase the reporting requirement for multi-corporation hospital systems, some of which have 50, 100, or even 150 corporate subsidiaries. Further, it is not clear how such additional reporting would increase compliance (as the current Form 990 is sufficient to ensure compliance), nor how such additional reporting would increase transparency or provide any valuable information to members of the public reviewing the Form 990. For example, in a multi-hospital system, does it increase compliance or transparency to require a hospital to report: a transfer of used examination tables from one of its hospitals to one of its clinics (or any one of a hundred or thousand other similar transfers); or to report the thousands of inter-company transfers (some of which—like sweep accounts—occur daily) that appear on the books of the related organizations; or to report the numerous services (contracting, purchasing, human resources, IT) that the corporate parent performs for every one of its subsidiaries?

Here are some other examples of the scope of the increased reporting requirements:

- To the extent that the controlling organization reports transfers to and from a controlled organization (as is the case in the current Form 990 to ensure compliance with the unrelated business income rules), is it necessary for the controlled organization to report the same transfer? This would be the case with the proposed Schedule K. Both the transferring and transferee organizations would have to report the same transfer, thus requiring duplicative reporting.

- To the extent that the current Form 990 already requires reporting of transfers between the controlling and controlled organization (i.e., between tax-exempt entities and the for-profit entities they control), does it serve the goals of compliance and transparency to require the additional reporting of all transfers between two tax-exempt entities? Transfers between two tax-exempt entities do not raise compliance issues and, as stated above, such transfers (e.g., of used examination tables) do not raise transparency issues.

- To appreciate the full scope, consider an organization that has 100, or even 50, corporations in its system (not an uncommon occurrence). Between any two entities there could be hundreds or even thousands of separate transfers per year (of cash, equipment, services, etc.). For every one of the corporations to prepare a list of every transfer to and from every one of the other corporations could be a mammoth undertaking that would provide little useful information to the IRS or the public.

Compliance with the current Form 990 is manageable if not slightly burdensome. Compliance with the proposed Schedule K would require rigorous efforts to ascertain the information. An organization could conceivably be reporting thousands of transfers, the overwhelming majority of which no one cares about. Moreover, the ones the IRS and the public *do* care about (namely, the transfers between the tax-exempt entity and less-than-wholly-owned taxable entities) could be buried in the thousands of other transfers and hard to identify, thus subverting the goal of transparency. For all these reasons, CHA believes that the proposed Schedule R should be deleted and replaced with Part XI from the current Form 990 (2006), a form that satisfies the requirements of compliance and transparency.

If some version of the Schedule R remains, CHA does not believe that any transfer, service, etc. between exempt organizations or between exempt organizations and wholly-owned taxable subsidiaries should be required (other than what is currently required by Part XI of the current Form 990 (2006)). Rather, the only transfers, services, etc. that should be reported are those between an exempt entity and a less-than-wholly-owned taxable subsidiary. These are the only transfers that arguably need to be disclosed for transparency and compliance purposes.

CONCLUSION

In closing, CHA views the draft redesigned Form 990 and Schedules as an important step towards achieving increased disclosure, transparency and compliance. We are pleased that the IRS based Schedule H in large part on the work of CHA in the charity care and community benefit area. Finally, we thank you for providing CHA the opportunity to share these comments with you. We think these comments will contribute to improving the Form 990 and help the IRS better achieve its goals. We look forward to working with you on these and other issues that continue to challenge and make stronger the nation's nonprofit hospitals.

Sincerely,

Sr. Carol Keehan
President and CEO

Attachments

Attachment A – New Parts I and II for Schedule H

Attachment B – New Question to Permit Aggregation

Attachment C – Revised Worksheets

Attachment D – Revised Schedule H, Part IV

ATTACHMENT A

SCHEDULE H (Form 990)	Hospitals	OMB No. 1545-XXXX
Department of the Treasury Internal Revenue Service	►To be completed by organizations that answer "yes" to Form 990, Part VII, Line 9.	20XX Open to Public Inspection

Part I

1. Name of filing organization — Employer identification number

2. Type of facility: (check all that apply):

- ☐ **Children's hospital**
- ☐ **Critical access hospital**
- ☐ **Research hospital**
- ☐ **Rural hospital**
- ☐ **General Acute Care Hospital**
- ☐ **Sole Community hospital**
- ☐ **Teaching hospital**
- ☐ **Urban hospital**
- ☐ **Other service attributes (please describe)**

_____

_____

Part II Community Benefit Report

1. Describe how the organization assesses the health care needs of the communities it serves. **[Include live link to web page.]**

2.a Does the organization or a related organization prepare an annual community benefit report? **[Include live link to web page.]** ☐ **Yes** ☐ **No**

b If yes, is it made available to the public? ☐ **Yes** ☐ **No**

3.a Does the organization have a charity care/financial assistance policy? ☐ **Yes** ☐ **No**

b If yes, describe. Include in the description whether the organization (a) bases eligibility for free or discounted care on federal poverty guidelines, income or asset levels, (b) applies such policy to all of its facilities and allows its facilities to adapt its policy to particular community or individual needs, and (c) budgets annually for charity care. **[Include live link to web page.]**

4. Describe how the organization's patient intake process informs and educates patients about their eligibility for assistance under federal, state, or local government programs or under the organization's charity care policy, if applicable.

5.a Does the organization operate an emergency room? ☐ **Yes** ☐ **No**

b If yes, is it operated 24 hours a day? ☐ **Yes** ☐ **No**

c Other than for being at capacity, or as otherwise permitted by law, did your emergency room deny services to anyone who needed emergency services? ☐ **Yes** ☐ **No.** If yes, explain.

6. Is admission to the medical staff open to all qualified physicians in the area, consistent with the size and nature of the facilities? ☐ **Yes** ☐ **No**

If no, explain _____

7. Does the hospital have a governing body in which independent members of the governing body represent the interests of the community?

☐ **Yes** ☐ **No**

8. Does the hospital engage in scientific or medical research, including clinical trials? ☐ **Yes** ☐ **No**

9. Does the hospital participate in training and education of health care professionals? ☐ **Yes** ☐ **No**

10. Does the hospital participate in Medicare, Medicaid, and/or other government-sponsored health programs? ☐ **Yes** ☐ **No**

11. Explain how the organization calculates bad debt expense.

12a Does the organization have a written debt collection policy? ☐ **Yes** ☐ **No**

b If yes, describe.

13.a Does the organization have a fundraising program to support community benefit activities? ☐ **Yes** ☐ **No**

b Does a related organization have a fundraising program to support community benefit activities? ☐ **Yes** ☐ **No**

c If yes, describe. _____

14. Provide any other information important to describing how the organization's hospital facilities or related organizations further the hospital's exempt purpose. **[Include live link to web page.]**

ATTACHMENT B

Proposed new Schedule H, Question 12, Part III (formerly Part I)

12a. Does the organization have non-hospital entities that meet the definition of a "related organization" and are part of its community benefit efforts? Yes__ No___

b. If yes, what is the aggregate amount of community benefits provided by these related organizations using the categories described in Part III, lines 1 through 11. $_____

c. List the name and EIN for each related organization included in the Line 12.b. aggregation

d. In addition to preparing schedule H for the organization, the organization is permitted (but not required) to prepare Part III **[formerly Part I]**, lines 1-11 on an aggregated basis for the organization and any of its "related organizations" listed above.

e. In addition to preparing schedule H for the organization, the organization is permitted (but not required) to prepare a separate Part III **[formerly Part I]**, lines 1-11 for each separate facility within the organization that provides community benefit (for example, if the organization has two hospital facilities and one outpatient clinic, all of which provide community benefit).

f. If the organization is the parent entity of a group of "related organizations" that operate hospitals and provide community benefit, the parent organization is permitted (but not required) to attach a Schedule H that reports the aggregate community benefit of all its "related organizations." This applies to parent organizations whether or not they directly operate hospitals and whether or not they would otherwise be required to prepare a Schedule H.

Name of entity EIN

ATTACHMENT C -- REVISED WORKSHEETS

Form 990 Hospital Schedule--Community Benefit Worksheets

These worksheets can be used to account for and report community benefit programs and services in Part I of the form 990 Hospital Schedule.

Worksheets

1 Net Cost of Charity Care
2 Ratio of Costs to Charges
3 Net Cost of Medicaid and Other Means Tested Public Programs
4 Summary of Net Costs of Community Health Improvement Services
5 Net Cost of Health Professions Education
6 Net Cost of Subsidized Health Services
7 Net Cost of Research
8 Cash and In-Kind Donations

Worksheet 1
Net Cost of Charity Care

Use this worksheet to calculate the net cost of charity care using a ratio of cost to charge or cost accounting system.

Calculation of the Net Cost of Charity Care		
	Method 1: Ratio of cost to charges	**Method 2: Cost accounting system**
Charges forgiven for charity care[1]		
1. Inpatient charity care charges	$	$
2. Outpatient charity care charges	$	$
3. Total charges (add lines 1 and 2)	$	$
Cost of charity care		
4. Ratio of costs to charges (from Worksheet 2)		
5. Estimated costs (line 3 x line 4 for Method 1)	$	$
6 Other direct contributions made by the organization to charity care programs[2]	$	$
7. Total charity care costs (add lines 5 and 6)	$	$
Revenue received to support charity		
8. Payments from uncompensated care pools or programs[3]	$	$
9. Philanthropy received and/or used to support charity[4]	$	$
10. All other sources of funding[4]	$	$
11. Total direct offsetting revenue (add lines 8-10)	$	$
Net Cost of Charity Care (line 7 minus line 11)	$	$

[1] *Charity Care* represents the amount forgiven (discounted) by the hospital or provider of medical care services to patients deemed unable to pay all or a portion of their bill for medical care, pursuant to financial assistance policies.

[2] Amounts donated by the hospital or medical care provider to charity care provided by other entities.

[3] Organizations should follow the intent of their legislature/Medicaid program regarding the reporting of Medicaid DSH funds. Amounts can be reported as direct revenue for charity care or for Medicaid services.

[4] Include philanthropy, grants, or other resources that are restricted by the donor/grantor to be used for charity care.

Worksheet 2
Ratio of Cost to Charges

Use the formula below to calculate a ratio of cost to charges.

Total Costs

1.	Total operating expenses (including bad debt)	$ _____
	Less: Adjustments	
2.	Other operating revenue[1]	$ _____
3.	Total community benefits expenses[2]	$ _____
4.	Total adjustments (add lines 2 and 3)	$ _____
5.	Adjusted total operating expenses (line 1 minus line 4)	$ _____

Total Charges

6.	Total Gross charges (including bad debt)	$ _____
	Less: Adjustments	
7.	Gross charges for community benefit programs[3]	$ _____
8.	Adjusted total gross charges (line 6 minus line 7)	$ _____

Calculation of Ratio of Costs to Charges

9.	Adjusted total operating expenses (line 5)	$ _____
10.	Adjusted total gross charges (line 8)	$ _____
11.	Calculated cost-to-charges ratio (line 9 ÷ line 10)	_____

[1] Reduce operating expenses for the amount of other operating revenue that has an associated operating expense. Some operating revenue or income (e.g., from joint ventures) should not be included in the adjustment.

[2] This line should include total expenses for community benefits to which the ratio of cost to charges is not applied. The purpose is to avoid double-counting these expenses in the ratio of cost to charges.

[3] This line should include gross charges for community benefits to which the ratio of cost to charges is not applied.

Worksheet 3
Net Cost of Medicaid and Other Means Tested Public Programs

Use this worksheet to determine the unpaid costs of Medicaid and other means tested public programs.

Net Costs of Means Tested Public Programs	Medicaid	Other means tested public programs	Total
1. **Total program expenses**[1]	$	$	$
2. Medicaid or provider taxes[2]	$	$	$
3. Total expenses (add lines 1 and 2)	$	$	$
Reimbursement and other support			
4. Inpatient reimbursement[3]	$	$	$
5. Outpatient reimbursement	$	$	$
6. Payments from uncompensated care pools or programs[4]	$	$	$
7. Total reimbursement and other support	$	$	$
8. **Net Cost of Medicaid and Other Means Tested Public Programs** (line 3 minus line 7)	$	$	$

[1] Total program expenses can be derived from (a) cost accounting system, (b) program cost report, or (c) the application of the ratio of costs to charges to program gross charges. Organizations should use cost accounting systems if they are available and well maintained.

[2] Include if you report Medicaid or provider taxes as operating expense rather than accounting for these amounts as an adjustment to net patient revenue.

[3] Do not include Medicaid GME reimbursement. This revenue should be reported on Worksheet 5, Net Cost of Health Professions Education.

[4] Organizations should follow the intent of their legislature/Medicaid program regarding the reporting of Medicaid DSH funds. Amounts can be reported as direct revenue for charity care or for Medicaid services.

Worksheet 4
Net Cost of Community Health Improvement and Other Community Benefit Services

	Activities or Programs	Direct Expense	Indirect Expense	Total Community Benefit Expense	Direct Offsetting Revenue	Net Cost
Community Health Improvement Services[1]						
A.		$	$	$	$	$
B.		$	$	$	$	$
C.		$	$	$	$	$
D.		$	$	$	$	$
1.	Total Community Health Improvement Services	$	$	$	$	$
Community Building Services[2]						
A.		$	$	$	$	$
B.		$	$	$	$	$
C.		$	$	$	$	$
D.		$	$	$	$	$
2.	Total Community Building Services	$	$	$	$	$
Community Benefit Operations[3]						
A.		$	$	$	$	$
B.		$	$	$	$	$
C.		$	$	$	$	$
D.		$	$	$	$	$
3.	Total Community Benefit Operations	$	$	$	$	$
4.	Total Community Health Improvement and Other Community Benefit Services (add lines 1, 2, 3)	$	$	$	$	$

[1] *Community Health Improvement Services* means activities carried out or supported for the express purpose of improving community health. They extend beyond patient care activities and are usually subsidized by the health care organization. Community services do not generate patient bills, although there may be a nominal fee or sliding fee scale.

[2] *Community Building* means activities carried out or supported to improve social factors found to be key determinants of health in communities: housing, education, environment, and economic prosperity.

[3] *Community Benefit Operations* means community health needs assessments and/or asset assessments, and other costs associated with community benefit strategy and planning.

Worksheet 5
Net Cost of Health Professions Education

Use this worksheet to calculate the net costs of health professions education.

Health Professions Education Costs[1]

1.	Medical students	$
2.	Interns, Residents and Fellows	$
3.	Nursing	
4.	Other allied health professions	$
5.	Continuing health professions education if open to all in the community	$
6.	Total education costs (add lines 1-5)	$

Funding sources[2]

7.	Direct Medicare reimbursement for GME[3]	$
8.	Direct Medicaid GME reimbursement	$
9.	Continuing health professions education reimbursement/tuition fees	$
10.	Other explicit support of education programs[4]	$
11.	Total education revenue/reimbursement (add lines 7-10)	$

Net Cost of Health Professions Education (line 7 minus line 12) $

[1] For all direct costs include related Administrative and General (overhead) costs. If the hospital supports the medical school library, those costs are included in Administrative and General. The following are considered Direct Costs (lines 1 - 5):

a. Stipends, fringe benefits of interns and residents; salaries and fringe benefits of faculty directly related to intern and resident education

b. Salaries and fringe benefits of faculty directly related to teaching of medical students

c. Salaries and fringe beenefits of research trainees (PhD students, post-doctoral students, MD-PhD students); salaries and fringe benefits of faculty directly related to education of research trainees

d. Salaries and fringe benefits of faculty directly related to teaching of students enrolled in degree-granting nursing programs

e. Salaries and fringe benefits of faculty directly related to teaching of students enrolled in degree-granting and/or certificate allied health professions education programs, including, but not limited to pharmacy, occupational therapy, laboratory.

f. For continuing health professions education open to all in the community, count salaries and fringe benefits of faculty for teaching continuing health professions education, including payment for development of on-line or other computer-based training that is accepted as continuing health professions education by the relevant professional organization

[2] Funding sources do not include Indirect Medical Education reimbursement provided by Medicare or Medicaid. (Costs also exclude IME-related cost).

[3] "GME" is "Graduate Medical Education." Include Federal Children's Hospital GME.

[4] Grants from any source

Worksheet 6
Net Cost of Subsidized Health Services

Use this worksheet to report financial information for each qualifying subsidized health service.

Calculation of Net Costs of Each Subsidized Health Service

	Program Name: _____	**Total program** (A)	**Medicaid and Other Means Tested Public Programs** (B)	**Charity care** (C)	**Program net of Medicaid and charity care** (A) – (B) – (C)
	Charges				
1.	Inpatient	$	$	$	$
2.	Outpatient	$	$	$	$
3.	Total charges (add lines 1 and 2)	$	$	$	$
4.	**Total expenses**[1]	$	$	$	$
	Reimbursement and other support				
5.	Inpatient	$	$	$	$
6.	Outpatient	$	$	$	$
7.	Other support[2]	$	$	$	$
8.	Total reimbursement and other support (add lines 5-7)	$	$	$	$
9.	**Net Cost of Subsidized Health Services** (line 4 minus line 8)	$	$	$	$

Subsidized Health Services means clinical services provided despite a financial loss, when the financial loss is so significant that negative margins remaina after removing the amounts of charity care and Medicaid shortfalls. Nevertheless, the organization provides the service because it meets an identified community need. If no longer offered, the service would either be unavailable in the community or become the responsibility of government or another not-for-profit organization.

[1] Total program expenses can be derived from (a) cost accounting system or (b) the application of the ratio of costs to charges to program gross charges. Organizations should use cost accounting systems if they are available and well maintained. The same cost accounting method used for Worksheet 3 (Net Cost of Medicaid and other Means-Tested Public Programs) should be used for Worksheet 6, if possible.

[2] Include philanthropy, grants, or other resources that are restricted by the donor/grantor to be used for subsidized health service.

Worksheet 7
Net Cost of Research

Use this worksheet to calculate the net cost of research[1]

Costs of research funded by a governmental or non-profit entity[2]

1.	Direct expense	$
2.	Indirect expense	$
3.	Total research costs (add lines 1 and 2)	$

Funding sources

4.	Grant or contract dollars received from a governmental or a non-profit entity	$
Net Cost of Research (line 3 minus line 4)		$

[1] Neither expenses nor revenues from for-profit companies for clinical trials are included. *Research* includes any effort of which the goal is to generate generalizable knowledge, such as about underlying biological mechanisms of health and disease, natural processes or principles affecting health or illness; evaluation of safety and efficacy of interventions for disease such as clinical trials and studies of therapeutic protocols; laboratory based studies; epidemiology, health outcomes and effectiveness; behavioral or sociological studies related to health, delivery of care, or prevention; studies related to changes in the health care delivery system; and communication of findings and observations (including publication in a medical journal).

[2] Examples of costs of research include, but are not limited to: Salaries of researchers and staff (including stipends for research trainees—either Ph.D. candidates or fellows); Facilities (including research, data, and sample collection and storage; animal facilities); Equipment; Supplies; Tests conducted for research rather than patient care; Statistical and computer support; Compliance (e.g., accreditation for human subjects protection; biosafety; HIPAA); and Dissemination of research results.

Worksheet 8
Cash and In-Kind Donations to Others

Date	Donated To	Amount

Cash Donations

A.	__/__/____		$
B.	__/__/____		$
C.	__/__/____		$
D.	__/__/____		$

1.	Total Cash Donations	$

In-Kind Donations

A.	__/__/____		$
B.	__/__/____		$
C.	__/__/____		$
D.	__/__/____		$

2.	Total In-Kind Donations	$

3.	Total Cash and In-Kind Donations (add lines 1 and 2)	$

Cash and in-kind donations means contributions made by the organization to health care organizations and other community groups to improve the health of the community.

ATTACHMENT D

Part IV **Facility Information**

(A) Provide the name and address of each of the organization's facilities.	(B) What type of service is provided at this facility?
Name _____ Address _____ City & State _____	
Name _____ Address _____ City & State _____	
Name _____ Address _____ City & State _____	
Name _____ Address _____ City & State _____	
Name _____ Address _____ City & State _____	
Name _____ Address _____ City & State _____	

From:	Michael.Grisdale@cheboyganhospital.org
To:	*TE/GE-EO-F990-Revision;
CC:	
Subject:	Comments on Redesigned Form 990 and Schedule H
Date:	Wednesday, September 12, 2007 4:07:32 PM
Attachments:	Form 990 letter.doc

Attached is letter containing our comments on Redesigned Form 990 and Schedule H.

Mike Grisdale, Director of Public Relations
Cheboygan Memorial Hospital
Cheboygan, Michigan

(See attached file: Form 990 letter.doc)

September 12, 2007

Internal Revenue Service
Form 990 Redesign, SE:T:EO
1111 Constitution Avenue, NW
Washington D.C. 20224

Dear IRS Representative:

On behalf of Cheboygan Memorial Hospital, thank you for the opportunity to comment on the new proposed Form 990 and specifically Schedule H pertaining to hospitals.

We appreciate the work that the IRS has put into the new form and schedules and its openness to comments from the hospital community. We are in agreement with the IRS's underlying guiding principles in redesigning the Form 990: enhancing transparency to provide the IRS and the public with a realistic picture of the organization; promoting compliance by accurately reflecting the organization's operations so the IRS may efficiently assess the risk of noncompliance; and minimizing the burden on filing organizations.

However, we have serious concerns about the proposed redesigned Form 990 and its related schedules, most notably Schedule H. Based on the proposed Form 990, it is clear that it will no longer be used just for reporting income and expense to the IRS. Instead, it will become an SEC-like disclosure document where narrative and factual information is collected and will contain a vast store of readily available information about the charitable and financial activities of an organization, its policies, governance structure, both charitable and financial, and the extent to which these organizations engage in financial transactions with hospital insiders or engage in transactions with other entities.

Based on our review, we have several primary concerns with the redesigned Form 990 and its related schedules that we are asking the IRS to address:

- The filing deadline proposed by the IRS for the new Form 990 is too short and should be extended.
- The IRS limits the full measurement of community benefit and is requesting information that is unrelated to the requirements for tax exemption. Such information

will be confusing and not be meaningful to the public. This information may wrongly become *de facto* standards and measurements by which the public and others may judge whether our hospital deserves its ongoing tax exemption. Such questions should be removed from Form 990 or otherwise revised.

Given the number of questions and concerns about the redesigned Form 990 and its related schedules that have been raised, we would urge the IRS to consider providing a second draft in early 2008, taking into account the comments received regarding the initial draft. This second draft should then be subject to another review period toward the goal of finalizing the schedule by December 31, 2008 and implementation in 2010. That would give hospitals sufficient time to revise their financial and data record-keeping systems in order to track and capture new information that will need to be reported without needlessly exhausting our resources.

We urge you to work with the hospital community to identify and resolve these and other issues before asking us to file anew Form 990 or any of its schedules. Thank you for the opportunity to comment on draft Form 990 and in particular Schedule H.

Sincerely,

Mike Grisdale, Director of Public Relations
Cheboygan Memorial Hospital
748 South Main Street
Cheboygan, MI 49721
(231) 627-1353